

# IMPLEMENTING THE 1998 TORTURE VICTIMS RELIEF ACT

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## HEARING BEFORE THE SUBCOMMITTEE ON AFRICA, GLOBAL HUMAN RIGHTS AND INTERNATIONAL OPERATIONS OF THE COMMITTEE ON INTERNATIONAL RELATIONS HOUSE OF REPRESENTATIVES ONE HUNDRED NINTH CONGRESS FIRST SESSION

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JUNE 23, 2005  
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## **IMPLEMENTING THE 1998 TORTURE VICTIMS RELIEF ACT**

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**THURSDAY, JUNE 23, 2005**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON AFRICA, GLOBAL HUMAN RIGHTS  
AND INTERNATIONAL OPERATIONS,  
COMMITTEE ON INTERNATIONAL RELATIONS,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 2:05 p.m. in room 2172, Rayburn House Office Building, Hon. Christopher H. Smith (Chairman of the Subcommittee) presiding.

Mr. SMITH. The Subcommittee will come to order. Good afternoon.

In the 25 years that I have been in Congress, I have had the privilege to work on a number of human rights issues around the globe both through the International Relations Committee and through the Commission on Security Cooperation, which I co-chair. Through this work I have met incredible, inspiring individuals. Sadly, I have also encountered many heartbreaking, gut-wrenching stories as well, and many of those stories involve people who have been tortured, from Cuba to China, from Saudi Arabia to Uzbekistan and Turkmenistan, and many other countries where torture is practiced with terrible savagery on people who are victimized by it. I have learned that unspeakable acts of torture are common, and unfortunately, they are effective tools of repression.

These compelling personal testimonies led me to author the Torture Victims Relief Act a decade ago, a bipartisan piece of legislation that Tom Lantos, my good friend and colleague and the Ranking Member of this Committee, also played a major effort in crafting. This law was also crafted and written with the invaluable input of internationally respected leaders in the field of torture relief, such as Doug Johnson who will testify later today, John Salzborg, and others. Designed to help address the continuing worldwide problem of torture and its lingering effects on torture survivors, the law promotes treatment for the severe psychological and physical consequences of torture. With medical, psychological and social services, torture survivors have found healing and are stable and productive members of their communities.

We now have several years of experience in implementing the Torture Victims Relief Act, and we have learned many valuable lessons that could apply to those who are still on our streets and on the streets throughout the world seeking and needing this kind of intervention.

In today's hearing we will hear from witnesses whose organizations have had first-hand experience with the law, and we look forward to hearing their testimony. We are fortunate that several of our witnesses are in Washington to mark United Nations International Day in Support of the Victims of Torture. I regret that Dr. Wade Horn from the Department of Health and Human Services is out of town, unable to testify, but he has offered us a statement that we will include as part of the record.

[The information referred to follows:]

PREPARED STATEMENT OF WADE F. HORN, PH.D., ASSISTANT SECRETARY FOR  
CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the Subcommittee, I am pleased to have the opportunity to share with you information on the Administration for Children and Families' efforts to implement the Torture Victims Relief Act of 1998. The Administration supports reauthorization of the Torture Victims Relief Act currently authorized through September 30, 2005.

The Torture Victims Relief Act addresses a major problem—the infliction of torture by foreign governments, and the consequences of that torture, on victims now living in the United States. It has been estimated that over 400,000 victims of torture by foreign governments now reside in the United States. These victims have suffered atrocities such as brutal beatings, electric shock, sexual assault and rape, and severe burns. The mental and physical harm that these torture survivors have endured impairs their ability to fully participate in the economic and social opportunities offered by this country.

Prior to the Torture Victims Relief Act, the types of specialized treatment needed by victims of torture had been available in only a few specialized centers. The need for treatment for the many victims of torture living throughout this country far exceeded available facilities. Many service providers were unaware of the special needs of this population so that, even when victims of torture sought services, appropriate treatment that addressed the issue of torture was not being provided.

The Torture Victims Relief Act met this critical need through funding that allowed the expansion and development of the kinds of programs needed to assist these victims to overcome the effects of the torture they have suffered and to live satisfying and productive lives in this country.

The Torture Victims Relief Act is particularly notable both for providing critically needed services and for assisting providers in making available the best possible help. The Act recognizes that torture survivors require a range of services, including rehabilitative treatment, social services, and legal assistance, tailored to the particular needs of each victim of torture. The experience of torture affects different people differently, and the combination of services that is relevant to the victim of torture varies from one individual to the next.

The Torture Victims Relief Act also is notable for its recognition of the need for research and for training of service providers outside of the treatment centers that focus on torture. The treatment of victims of torture is a new and very complex field. Torture affects many areas of a person's life, beyond the physical effects. Research into best practices is critical to ensuring that torture survivors receive the care that they need. Victims of torture live throughout this country, and training and technical assistance to health care providers outside of treatment centers in appropriate services for victims of torture helps to ensure that there will be knowledgeable providers wherever victims of torture are living.

The Administration for Children and Families implemented the Torture Victims Relief Act by focusing on funding organizations that provide direct services, including rehabilitative, social and legal services to victims of torture. The Administration for Children and Families also has funded one organization to provide technical assistance to organizations that serve persons who have been tortured.

In FY 2000, (the first year for which funds were appropriated to implement the Torture Victims Relief Act), the Administration for Children and Families awarded four-year grants to 17 organizations. Of these organizations, 15 provided services to victims of torture; one organization pursued legal issues involved with prosecuting torture perpetrators; and one of these grants was awarded to the Center for Victims of Torture in Minnesota for the provision of technical assistance to other service providers.

The following year, in FY 2001, the Administration for Children and Families awarded three-year grants to another 9 organizations around the country to provide direct services to victims of torture.

Most recently, in FY 2004, ACF awarded grants to 26 organizations to provide direct services. And one grant was awarded again to the Center for Victims of Torture to continue to provide technical assistance to other service providers who assist victims of torture.

Agencies funded through the Services for Victims of Torture program have provided a combination of mental health, medical, legal, and case management services. Mental health services have consisted of diagnostic evaluation, psychotherapy and counseling, pharmacological intervention, and group therapy. Medical services have included diagnostic evaluation, treatment for head injuries and other trauma, and other kinds of medical assistance. Legal services have included legal evaluation and assistance with immigration status. Other services have included assistance with housing, employment services, transportation assistance, English as a Second Language, and translation and interpretation services.

The 26 organizations currently funded under this program are located in 17 States. The States are: California, Colorado, Florida, Georgia, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New York, Oregon, Pennsylvania, Texas, Utah and Virginia.

At the end of FY 2004, the organizations that had originally been awarded grants in FY 2000 and FY 2001 reported that they had provided services to approximately 6,600 victims of torture. These grantees reported that, of the victims of torture served, 3,922 received mental health services, 2,753 victims of torture received medical services, 2,649 were provided legal assistance, and 4,399 received other kinds of social services. These services have been provided directly by grantees or their partner agencies or have been provided through referral to other organizations.

An important component of this program has been the provision of technical assistance through the Center for Victims of Torture. This organization also maintains a clinic through which direct services are provided to victims of torture.

During the four-year period that ended on September 29, 2004, the Center for Victims of Torture provided technical assistance to thirty-seven organizations that serve victims of torture. Of these organizations, 25 had received grants through the Victims of Torture program; 5 organizations had received funding as sub-grantees; and 7 organizations that serve victims of torture without a direct grant from the program received technical assistance from the Center for Victims of Torture.

The main goal of the technical assistance grant to the Center for Victims of Torture has been to expand and enhance treatment facilities for victims of torture living in the United States. The Center for Victims of Torture has provided knowledge and innovative expertise to treatment facilities in the areas of clinical service, organizational structure, data collection, and technology through on-site consultations, individual program assessments, and technical assistance plans.

The Center for Victims of Torture also has conducted a series of mini-institutes. Over the four-year grant period that ended in September 2004, 518 participants took part in these mini-institutes. The institutes covered such topics as clinical methods, clinical and administrative leadership, and report writing.

The technical assistance provided by the Center for Victims of Torture has been vital to the Services for Victims of Torture program both in ensuring that all organizations that receive funding are providing the most up-date services and in ensuring that other service providers who work with victims of torture have access to the same information on best practices in working with this population.

In conclusion, this program allows organizations that serve victims of torture vital funding to reach out to survivors of torture and provide the assistance they need in order to participate fully in their new lives in this country. I would like to thank the Subcommittee for its commitment to assisting victims of torture. I look forward to working with you on the reauthorization of this critical legislation, the Torture Victims Relief Act.

Mr. SMITH. Let me just finally say that there are approximately 400,000 torture victims in the U.S. We don't know how many torture victims are survivors throughout the world, but it is certainly in the millions, and everything we do is only just reaching a small percentage of those who are in need of service. As wars and conflicts proliferate, as torture is used as a method of political repression in places like China and North Korea, certainly the ranks of those who are in need of these services will grow. It is not, regret-

tably, diminishing. Hopefully this legislation that we will markup later today will expand our capabilities, especially on the domestic level where we look to boost rather significantly that which is earmarked and used for torture victims, from about \$10 million per year to \$25 million.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF THE HONORABLE CHRISTOPHER H. SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY AND CHAIRMAN, SUBCOMMITTEE ON AFRICA, GLOBAL HUMAN RIGHTS AND INTERNATIONAL OPERATIONS

In the years that I have been in the Congress, I have been privileged to work on human rights issues around the globe, both through the International Relations Committee and through my work as Chairman and Co-Chairman of the Helsinki Commission. Through this work, I have met incredible, inspiring individuals. Sadly, I have also encountered many heart-breaking, gut-wrenching stories as well, and many of those involve torture. From Cuba to China, from Saudi Arabia to Uzbekistan and Turkmenistan, I learned that unspeakable acts of torture are common—and effective—tools of repression.

These compelling personal testimonies led me to author the Torture Victims Relief Act a decade ago. This law was crafted with the invaluable input of internationally respected leaders in the field of torture relief, such as Doug Johnson, who will testify later today, John Salzburg, and others. Designed to help address the continuing world-wide problem of torture and its lingering effects on torture survivors, the law promotes treatment for the severe physical and psychological consequences of torture. With medical, psychological and social services, torture survivors have found healing and are stable and productive members of their communities.

We now have several years of experience in implementing the Torture Victims Relief Act. At today's hearing, we will hear from witnesses whose organizations have first-hand experience with the law, and I look forward to hearing their testimony. We are fortunate that several of our witnesses are in Washington to mark the United Nations International Day in Support of the Victims of Torture. I regret that Dr. Wade Horn, from the Department of Health and Human Services, is out of town and unable to testify today, but he has sent over a statement which will be included in the record.

#### WITNESSES

Our first witness today is *Lloyd Feinberg*, Manager of USAID's Victims of Torture Fund. Mr. Feinberg is responsible for the oversight and management of a portfolio of three special funds which provide over \$35 million annually in development assistance. These include the War Victims Fund, the Victims of Torture Fund and the Displaced Children and Orphans Fund. This program currently supports over 85 programs in more than forty-five countries in the Asia and Near East, Africa, Eastern Europe, and Central and Latin America regions.

Mr. Feinberg began his international career as a Peace Corps Volunteer in the Philippines in the mid 1960s and has over 40 years' experience managing social sector programs in developing countries. After the Peace Corps, and before joining USAID in 1984, he managed NGO development programs in Indonesia, Ethiopia, Nepal and Ecuador. From 1980—1983, he served as Project Manager on the World Bank Transmigration II project in Indonesia.

Accompanying Mr. Feinberg is *Danuta Lockett*, who currently works as a senior advisor for the Victims of Torture Fund. Her role is to provide technical guidance to the Fund and grantees in line with Fund's mandate. She has been instrumental in developing the Fund's guidelines and in providing technical input on program design, assessment and evaluation of country projects.

Dr. Lockett's career spans 20 years of work in the international development arena. She has worked for numerous development agencies and NGOs in Latin America, Asia, the Near East and Africa. Her technical expertise is in human rights and transitions related to conflict.

For our second panel of witnesses, we are joined by *Sheikh Sackor*. Mr. Sackor is a survivor of torture from Liberia. In 1997, he started an organization called Humanist Watch Liberia. As a result of speaking out for human rights and democracy, he was repeatedly imprisoned and tortured. Fearing for his life, he fled Liberia, and came to the United States, where in 2004, he was granted political asylum. Mr. Sackor, thank you for your courage in being here with us today.



*Dr. Allen Keller* is founder and director of the Bellevue/NYU Program for Survivors of Torture. This remarkable program is jointly sponsored by Bellevue Hospital, the Nation's oldest public hospital, and New York University School of Medicine, a leader in medical education and research. The Program provides comprehensive, medical, mental health and social services to refugees and asylum seekers who have suffered from torture and other human rights abuses. Dr. Keller is also chair of the Policy Committee of the National Consortium of Torture Treatment Centers, which includes 35 organizations in 21 states dedicated to advancing the knowledge, technical capacities and resources devoted to the care of torture survivors and acts collectively to prevent torture worldwide.

Finally, we are joined by *Douglas A. Johnson*. Mr. Johnson has, since 1988, been executive director of the Center for Victims of Torture, the oldest torture treatment center in the United States. CVT provides comprehensive care for victims of government-sponsored torture, conducts research and training, and undertakes policy efforts to commit the U.S. and other institutions to work against torture and aid torture survivors. Mr. Johnson also serves as an original member of the Organization for Security and Co-operation in Europe's Advisory Panel on the Prevention of Torture (established in 1998), and he has testified before Congress many times.

Mr. SMITH. I would like to now yield to my good friend and colleague Mr. Payne, fellow New Jerseyan, for any opening comments.

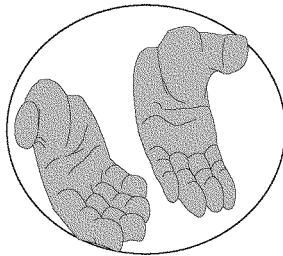
Mr. PAYNE. Thank you. Thank you very much, Mr. Chairman. And I commend you for calling this important hearing on the issue of torture, specifically looking at the implementation of the 1998 Torture Victims Relief Act, the TVRA. The bill, now Public Law 105-320, received strong bipartisan support, and I thank the Chairman for his commitment to and leadership on the issue of torture and for his work on human rights in general.

I ask unanimous consent that a report on violence in Zimbabwe from the Centre for the Rehabilitation of Torture Victims be entered into the record.

Mr. SMITH. Without objection, it will be so ordered.

[The information referred to follows:]

CENTRE FOR THE  
REHABILITATION  
OF  
TORTURE VICTIMS



CERETOV  
2003

**REPORT ON A SURVEY ON TORTURE AND  
VIOLENCE IN ZIMBABWE**

Report compiled by Research Unlimited, 18 Terry Drive, Greendale. Tel: 492537, 492064

## **CERETOV in brief**

### **CERETOV'S VISION**

Setting the stage for renewal and reintegration.

### **MISSION**

TO WORK TOWARDS THE RE-INTEGRATION OF TORTURE VICTIMS INTO SOCIETY.  
CERETOV SEEKS TO RESTORE DIGNITY  
TO THE DEHUMANIZED MEMBERS OF OUR SOCIETY THROUGH LONG-TERM STRATEGIES  
THAT ARE ALSO EMPOWERING AND EFFECTIVE IN BRINGING PSYCHOLOGICAL AND  
MENTAL STABILITY. WE STRIVE FOR RENEWAL AND THE RIGHT TO A DIGNIFIED LIFE.

### **OBJECTIVES**

- To research about torture.
- To empower survivors of torture.
- To counsel survivors of torture.
- To provide legal aid to survivors.
- To advocate against torture nationally and internationally
- To network with organizations that support human rights.
- To compile a Database of torture in Zimbabwe.

### **CERETOV: A BRIEF BACKGROUND**

**CERETOV** Zimbabwe Chapter is the brainchild of a group of torture victims who came together after having realised the effects of torture on their lives in particular and other silent victims in general.

Initially formed as a group in 2003 in Chitungwiza, the victims who met almost every Saturday to counsel each other decided to form an association that would attempt to engage many victims and find strategies for rehabilitation. CERETOV was registered as a Trust in November 2003 and is a non-partisan organisation that welcomes survivors of torture to be members and any other person who supports the cause of torture victims.

**Acknowledgements**

Ceretov salutes the individuals who accepted to be interviewed and to tell their story, together with the researchers who took the risk of going into the field to collect data. The tragedy of today's society is not only that there are evil people, but also that good people remain silent and let the evil take control.

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**Executive Summary**

This study reveals the prevalence of systematic violence targetted mainly at opposition supporters. The tradgedy of the situation is not only that a culture of violence is developing in our polity but also that the law enforcement agents turn a blind eye to it. However there is hope for the future in that there is the feeling that torturers can be rehabilitated back into their communities. While CERETOV is not yet well known, the consensus is that it is a vital organization in the fight to rid Zimbabwe of the scourge that is political violence. Society is expecting a lot from CERETOV. CERETOV must therefore be well poised to meet that expectation.

### **Rationale for the study**

1980 marked a watershed in the history of this country. After years of colonial rule, the country gained independence. With this independence came hopes of a bright future, a future free from the vagaries of the Ian Smith era. Prominent among such vagaries was the use of torture as a strategy to induce compliance. The year 2000 however saw the dashing of whatever remained of those hopes. The constitutional referendum in 2000 and subsequent parliamentary and presidential elections saw the return of torture and violence as a tool to induce conformity. CERETOV ZIMBABWE felt there was a need to document such acts in the first instance. Initially however it would be necessary to carry out a study to determine the extent of the problem, identify the source of the problem and map out a way forward among other things. The result is this report.

### **Sampling**

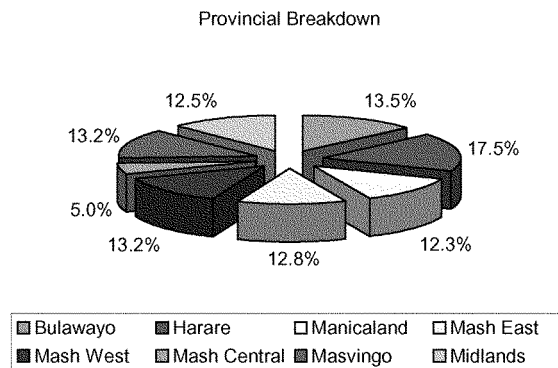
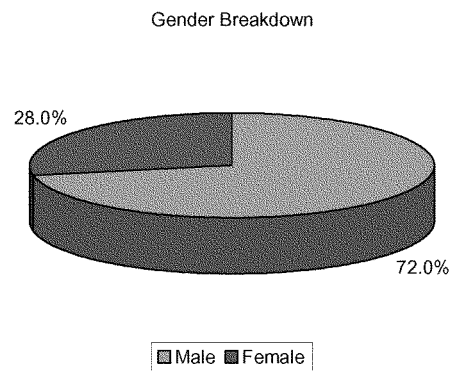
The sensitive nature of the study made it impossible to carry it out on the basis of a probability sample. The target group was individuals who themselves had been tortured or who had witnessed torture. Since most of these were in hiding or had deserted their homes it became very difficult to specify the probability that any case would be included in the sample. The nature of the cases therefore made it necessary to conduct non-probability sampling. Specifically, we adopted a method called "Snowball Sampling". We identified and made contact with organizations who could get us in touch with one or two victims of torture who in turn would identify further cases. The trend would continue until we had a number of cases which were sufficient to give us the kind of qualitative data we required. In this case the sample size was four hundred and twenty seven (427). The cases were drawn from eight of the ten political provinces of this country in varying numbers. No attempt was made to divide the questionnaire administration equally across the gender divide and across the various age groups. The questionnaires were administered by two Enumerators in each of the provinces that were visited.

### **Limitations of the study**

Three major limitations were identified during this study.

1. The lack of adequate funding meant that the methodology for the study was changed. Ideally, a nationally representative sample would have shed more light into the issue under review. The results of this study therefore cannot be used to generalize about the torture and violence situation in the country as a whole.
2. Identification of respondents proved extremely difficult. The study targetted those individuals who had expereinced torture and needless to say the majority of them if not all of them are traumitized and were reluctant to speak about their experiences. This meant a lot of time was spent in the field than would have been the case with a “normal” survey. In addition it was necessary to gain the confidence of the respondents in order for them to identify for us other potential respondents.
3. The political terrain meant a slow and careful navigation by our Enumerators. It was important to ensure not only their safety but that of the respondents as well. There are areas where the Enumerators could not venture to go because of security reasons. Matebeleland North and South were unentered mainly because the subject under discussion meant an opening of the wounds of the “Gukurahundi” era. Respondents therefore were uncomfortable discussing a subject such as torture and violence.



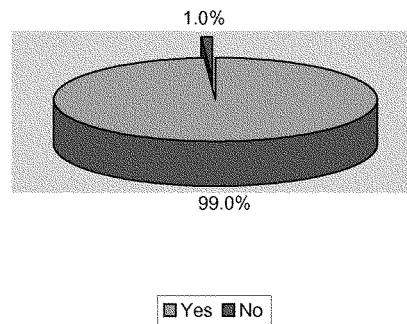
**Case processing summary****Fig 1: Provincial breakdown****Fig 2: Gender Breakdown**

## **Section A**

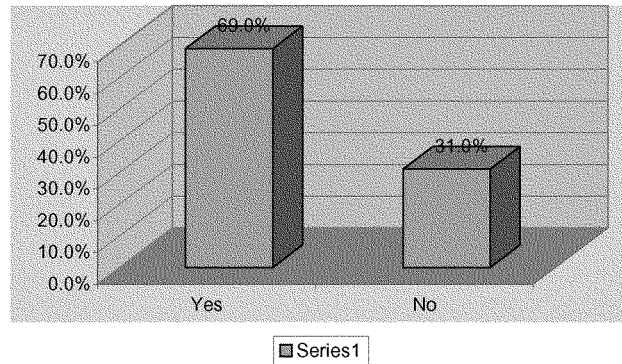
### **The Prevalence of Torture**

From the outset, the questionnaire sought to establish the prevalence of violence and torture. Respondents were asked whether there were any incidents of violence and torture in their places of residence.

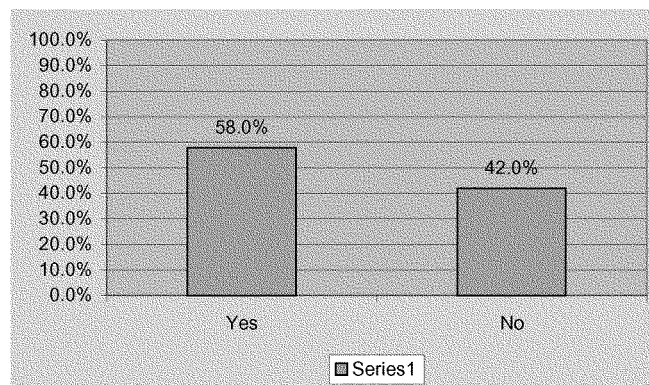
Figure 3: Incidents of violence and torture



That such an overwhelming majority of respondents attest to the existence of violence in their place of residence is significant. Also significant is that this view cuts across all the eight provinces in which interviews were carried out. These statistics carry more significance when compared with those of questions which sought to find out if respondents themselves or their family members had been victims of violence and torture.

**Figure 4:** Respondents as victims of torture

69% of the people interviewed had actually experienced torture themselves. The 99% who said there was violence and torture in their places of residence could theoretically have only heard about it. However it is significant that 69% actually went through the experience. This can therefore be interpreted to mean that there is a prevalence of violence and torture in this country. This is further buttressed by the statistics that show that 58.4% of the respondents have family members who themselves had also experienced torture.

**Figure 5:** Family members – Violence and torture

Two other indicators point to a high prevalence of violence and torture in Zimbabwe. The first are the responses to the question on who perpetrates the violence and torture. Respondents were able to name not only the broad location of the perpetrators but in

some instances identified the perpetrators by name. Such violence could only have taken place over a long time or to a great extent if the perpetrators can be identified by name. Secondly, respondents felt that violence and torture cut across the gender barrier as well. In terms of the gender more affected by the violence and torture, there is the view that both sexes are affected. Below is an outline of the responses.

**Table 1:** Gender more affected

Gender	% Affected
Male	23%
Female	44%
Both	32%

The questionnaire also tried to find out the ways in which the violence and torture are carried out. What emerges is that the forms of torture are similar across the different provinces. Respondents talk of systemic assaults, kidnappings, displacement and threats. This similarity in methods suggests similar perpetrators and in turn this suggests a well coordinated strategy.

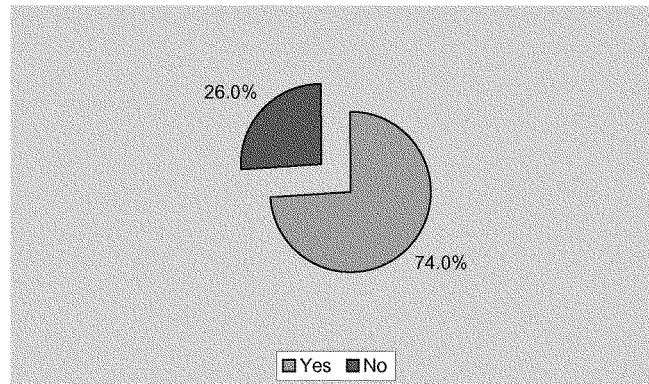
## **Section B**

### **The Rationale for Torture and the Perpetrators**

All the individuals who were interviewed linked the prevalence of violence and torture to politics and to elections in particular. It is a sad indictment of the conduct of political affairs in this country that people identify elections and political issues with violence.

1. When asked to point out who can stop the violence and torture, respondents identified the president and ZANU(PF). This also buttresses the fact that violence and torture are "born out of elections and the political dispensation of the day. In addition, this also points out the perceived perpetrators of these acts. Respondents identified the youth militia, security agents and war veterans as being responsible for this violence and torture.
2. Respondents identified the police as being reluctant to deal with the perpetrators of violence. Again this is an indicator of where the violence and torture is perceived to be emanating from. Ideally the police should be impartial. Their lack of enthusiasm suggests that those responsible have power over the police.
3. The majority of those who perpetrate violence and torture are known to the community. By implication this means that their political affiliations are known and consequently their "pay masters". The fact that they carry out these acts with impunity suggests that they can only be sent by those in positions of authority.

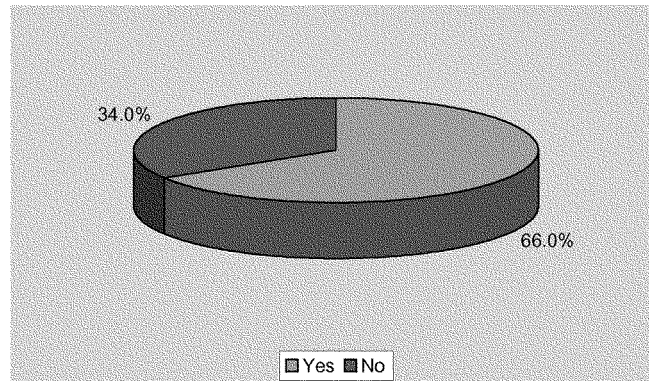
**Figure 6:** Are torture perpetrators known



### **Section C**

#### **What can be done about violence and torture**

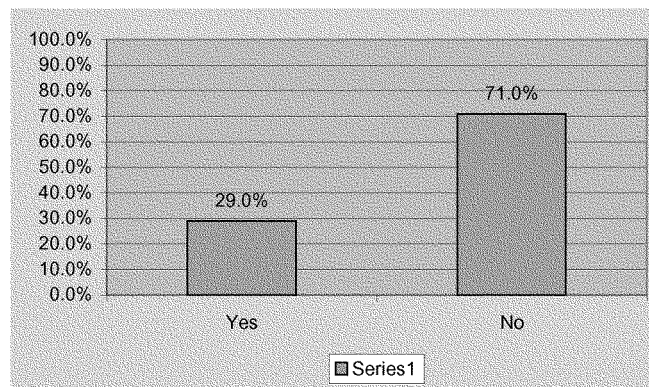
**Figure 7:** Can there be an end to torture



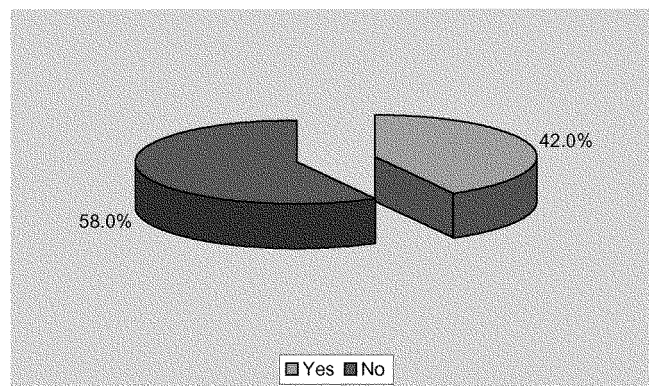
Despite the apparent prevalence of violence and torture and the systematic manner in which it is perpetrated, respondents feel confident that it can be brought to an end. However respondents are of the opinion that the perpetrators should not be forgiven and that they should not be accepted back into society.

It is important to note that respondents feel that they should be made accountable for their acts and should be punished in accordance with the laws as a precondition to their being accepted back into society. Opinion is almost split on the issue of acceptance back into society.

**Figure 8:** Should torturers be forgiven



**Figure 9:** Should torturers be accepted back into society

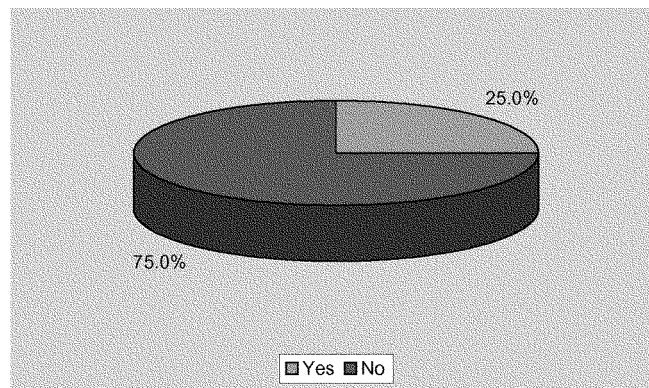


## **Section D**

### **CERETOV and the future**

The research reveals that the majority of respondents are not aware of the existence of CERETOV-Zimbabwe. This is hardly surprising considering that it was launched only recently.

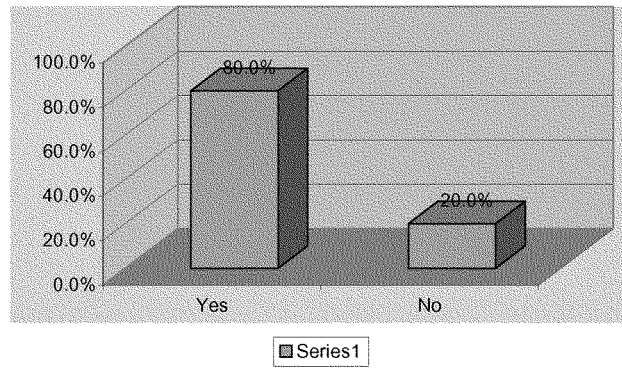
**Figure 9:** Awareness of CERETOV- Zimbabwe



However what is encouraging is the interest that is apparent among respondents. Apart from the eagerness to be members, respondents also came up with ways in which CERETOV-Zimbabwe could be of assistance to victims of violence and torture. Three major categories of assistance needs were mentioned and these are:

1. Medical assistance- Respondents revealed that more often than not victims of violence and torture are denied medical assistance when they approach hospitals and clinics.
2. Counselling services- Torture victims are severely traumatised and have to live with flashbacks all their lives
3. Shelter-Victims of torture and violence almost always are displaced and end up destitute.

Figure 10: Would you like to be a member of CERETOV-Zimbabwe





### Conclusions and recommendations

1. Violence and torture are prevalent in Zimbabwe. Authorities cannot turn a blind eye to this scourge on Zimbabwe's landscape. Intervention strategies ought to be formulated so that this problem can be dealt with and be exterminated.
2. The law enforcement agencies in this country have been implicated not only in terms of perpetrating violence themselves but also in "folding their hands" when it comes to assisting victims of violence and torture. A professional, non-partisan approach is required as this will go a long way in restoring public confidence in the law enforcement agencies.
3. The violence and torture appears systemic and planned. This culture in the conduct of public affairs in Zimbabwe should be done away with.
4. Respondents are hopeful that violence and torture can be brought to an end. However deep seated emotions exist. Respondents do not want the perpetrators to be forgiven and accepted back into society. This state of affairs calls for a strategy along the lines of the Truth and Reconciliation Commission of South Africa.
5. Awareness concerning CERETOV-Zimbabwe is still limited. It is incumbent upon the organization to market itself and make itself more visible not only to victims of violence and torture but to the country as a whole. People should be aware of what CERETOV has to offer. In the long run this will call for the establishment of provincial and perhaps even district offices to ensure easier accessibility.
6. CERETOV-Zimbabwe should equip itself in accordance with the needs espoused by the respondents. CERETOV-Zimbabwe should be in a position to offer medical and counselling services. Considering the responses from the respondents it may be necessary to set up special clinics where non-partisan medical attention will be provided. In addition there is a need to provide safe havens for victims of violence and torture.

Mr. PAYNE. Thank you.

I strongly support the changes proposed by the TVRA Reauthorization Act of 2005, H.R. 2017, a bill we will be marking up following this hearing, which will increase the funding for domestic bilateral and multilateral programs to assist survivors of torture. Specifically the bill authorizes \$25 million for fiscal year 2006 and \$25 million for 2007 to the Department of Health and Human Services to assist domestic treatment centers; \$12 million in fiscal year 2006 and \$13 million in fiscal year 2007 for centers and programs administered through USAID's Victims of Torture Fund; \$7 million for 2006 and \$8 million for 2007 for centers and programs administered through the U.N. Voluntary Fund for Victims of Torture.

Tomorrow, June 26, is United Nations International Day in Support of Victims of Torture. Article 7 of the International Covenant on Civil and Political Rights, the ICCPR, in part 7 states in part that: "No one shall be subjected to torture, cruel, inhumane or degrading treatment or punishment." Torture is also prohibited by common article 3 of the Geneva Conventions, which is binding on governments and armed opposition political groups. The article applies to persons taking no active part in hostilities and specifically prohibits violation to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture. The U.S. needs to hold governments and groups around the world accountable for abuses of human rights.

In Sudan, the world's most brutal regime, the act of torture in most cases is carried out by security officers and other government forces, particularly the military intelligence and the various police forces, against persons in police custody. We also know that torture is being carried out in the genocide in Darfur at an alarming rate.

I wish to also point out that the State Department's annual *Human Rights Report* of 2004 mentions the Governments of Equatorial Guinea, a top oil producer for the United States, and Cameroon that is particularly bad about systematic torturing of people, both regular suspects and also political activists. Zimbabwe is another country which needs serious attention for many reasons, but particularly for the use of torture against the Zimbabwean people.

I am pleased that we will hear from a torture survivor from Liberia today about his experiences, and I hope Liberia's days of trouble are behind us with Charles Taylor out of the country and with a United Nations operation going through, and hopefully elections will come about this year.

There are also reports of torture being carried out in Ethiopia and the Democratic Republic of Congo, Zambia and Tanzania. We also need to eradicate female genital mutilation, a form of oppression against girls in parts of Africa and the Middle East.

However, at the same time if we are going to be honest, the U.S. needs to improve its own record on human rights and torture both around the world and in our own hemisphere. We must criticize ourselves when it is necessary, and we are not above the law. We are not trying to sink down to the level of people who do it. And as General Colin Powell was one who was always strongly opposed to torture because he said he does not want that to happen to his men in the field, and sometimes what goes around will come around if you allow it to happen.

So, Mr. Chairman, let me thank you, and I look forward to the testimony of the witnesses.

Mr. SMITH. Thank you very much.

Tom Tancredo.

Mr. TANCREDO. Only this, Mr. Chairman, and I really wasn't going to make a statement. It is just that to the extent that we can ask for equal treatment of our prisoners, American prisoners, who may be held by someone else, I would hope that that would extend to asking even for the same sort of menu and the food that we provide our "prisoners" with. There are a lot of things that I want equity with around the world, and I would be happy if other countries that hold our prisoners would treat them as humanely as we treat ours.

Mr. SMITH. Ambassador Watson.

Ms. WATSON. Thank you so much, Mr. Chairman. I want to commend you for having this hearing today.

We are seeing the use of torture on the increase, particularly those who are captives in this war on terrorism. But more so than that, our visit to Chad and to the Sudan a few months back brought home the fact that we, as a leading Nation in the world, must do all we can to alleviate the torture that so many are suffering. We had the good fortune to travel with Don Cheadle and Paul Rusesabagina. He was the gentleman who was the manager in the hotel in Rwanda, and he described to us the atrocities that he had experienced and, bless him, that he was able to get out over 1,500 people and save them from the same kind of fate that many of his countrymen had already faced.

So we need to put strong teeth in our act. We need to be role models for the rest of the world, and those atrocities that took place in Abu Ghraib can never be duplicated again.

So thank you so much. I look forward to hearing from the witnesses. Thank you, Mr. Chairman.

Mr. SMITH. Thank you very much, Ambassador.

Betty McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

This is a very important and timely hearing because of—I share the remarks that were made by the Congresswoman, but we have so many things going on right now in the world, and we just had a Full Committee hearing on Sudan and what is going on there. And those of us who were there know not only how the adults have been scarred, but the scars that the children will carry with them. And it is happening all over the world. And we have the opportunity not only to heal, but to prevent, and the world is looking to us for leadership. So thank you for having this hearing, Mr. Chairman.

Mr. SMITH. Thank you very much.

Let me just welcome our first panel, beginning with Lloyd Feinberg, Manager of USAID's Victims of Torture Fund. Mr. Feinberg is responsible for the oversight and management of a portfolio of three special funds which provide over \$35 million annually in development assistance. These include the War Victims Fund, the Victims of Torture Fund and the Displaced Children and Orphans Fund. This program currently supports over 85 programs

in more than 45 countries in Asia and the Near East, Africa, Eastern Europe, and Central and Latin America region.

Mr. Feinberg began his international career as a Peace Corps volunteer in the Philippines in the mid-1960s and has over 40 years experience managing social sector programs in developing countries. After the Peace Corps and before joining USAID in 1984, he managed NGO development programs in Indonesia, Ethiopia, Nepal and Ecuador. From 1980 to 1983, he served as project manager on the World Bank's Transmigration II project in Indonesia.

Accompanying Mr. Feinberg is Danuta Lockett, who is currently serving as a senior advisor for the Victims of Torture Fund. Her role is to provide technical guidance to the fund and grantees in line with the fund's mandate. She has been instrumental in developing the fund's guidelines and in providing technical input on program design assistance assessment and evaluation of country projects.

Dr. Lockett's career spans 20 years of work in the international development area. She has worked for numerous development agency and NGOs in Latin America, Asia, the Near East and Africa. Her technical expertise is in human rights and transitions related to conflict.

Mr. Feinberg, if you could begin.

**STATEMENT OF MR. LLOYD FEINBERG, MANAGER OF THE VICTIMS OF TORTURE FUND, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT**

Mr. FEINBERG. Thank you very much, Mr. Chairman and Members of the Committee. We are very honored and pleased to be able to provide testimony today on the activities of the Victims of Torture program. And I just wanted to thank the Committee very much for all the support that you have provided and the guidance that you offer.

I would like for Dr. Lockett to present our testimony. She has been extremely effective and innovative in both refining and bringing professionalism to the oversight and the development of our programs under the Victims of Torture Fund. I think that she has performed extraordinarily well in the way that she has been able to work with our various missions in the field and to extend the number of activities that we have to broaden the approaches that are taken to have the most impact and to be able to adopt and adapt the approaches to working with victims of torture in ways that are culturally appropriate.

Dr. Lockett, please.

Ms. LOCKETT. One can't take on an assignment like this without the support of a good boss such as Lloyd Feinberg. So it is a pleasure for us to present together.

Mr. Chairman and Members of the Subcommittee, Lloyd and I are pleased to have the opportunity to share with you information on the U.S. Agency for International Development's effort to implement the Torture Victims Relief Act through the Victims of Torture Fund. The fund's mandate derives from the Torture Victims Relief Act, TVRA, which directs funding to the U.S. Agency for International Development for four main categories of service: Treatment and rehabilitation, training and research.

Envisioning a world free of torture where survivors, their families and communities receive the support they need to quell their suffering and rekindle their connection to everyday life, the fund primarily supports programs that help heal the psychological and physical trauma caused by torture. Additionally, the fund recognizes that communities, along with survivors, need to heal and recover. To this end it supports programs that affirm the dignity of the survivor by restoring his or her position as a functioning and contributing member of the family and the community.

The fund also recognizes that restoring the dignity of those affected by torture involves strategies that help societies understand the consequence of torture. Through awareness-raising and other meaningful activities, civil society can play an important role in protecting individuals against future acts of torture.

The fund works through nongovernmental organizations overseas that, (1) provide direct services to torture-affected survivors, their families and communities; (2) train individuals to treat and help restore the functioning of those affected by torture; and (3) increase the level of knowledge and understanding about the effectiveness of treatment and rehabilitation methods.

In keeping with the fund's mission, there are five principles guiding programming for torture survivors under the USAID torture victim fund mandate: Improving services and access to services to torture-affected communities; targeting individuals who suffer reduced function due to direct or indirect exposure to torture and communities with many such persons; building on existing community networks and resources; breaking the silence experienced by individuals in communities affected by torture; and finally, strengthening public response to torture in order to protect individuals against future incidents of torture. Toward this end the fund administers treatment programs based in 30 countries that span 4 regions.

Currently the fund is overseeing a total of 27 agreements for treatment programs that include attention to the medical, psychological and social needs of torture survivors and their families. Some of these programs include advocacy training, technical assistance and research. Our 27 major grantees are supporting another 99 local nongovernmental organizations which are based in the communities where survivors live. This multiplier effect is one of the major achievements of the fund as it strives to build the critical threshold of local services to support survivors as they seek to come to terms with the abuse they have suffered.

The 2003–2004 portfolio synopsis gives a more detailed perspective on the fund's programs. I have copies here for those who would like to have a chance to look at them. We are currently updating the information for a 2005 portfolio synopsis, which we expect will be ready by early fall.

Our funding guidelines are as follows: Funds from the Victims of Torture Fund are transferred to USAID overseas missions based on unsolicited proposals or mission requests for funding. The missions manage and negotiate grants and cooperative agreements with the agreed-upon partners.

In keeping with its legislative mandate, the Victims of Torture Fund gives priority to programs that treat and rehabilitate torture-

affected individuals. Country-based programs are, for the most part, implemented through grants and cooperative agreements to domestic, foreign and international and nongovernmental organizations that are registered with USAID's Office of Private and Voluntary Cooperation. In the majority of our programs, grantee organizations work in partnership with local NGOs capable of working with the needs of torture-affected survivors, their families and communities. Unsolicited concept papers and proposals can be submitted to USAID missions or to the Victims of Torture Fund manager.

Funding guidelines are also published in this portfolio synopsis, and this synopsis is also contained on our Web site, so it is readily available and public knowledge.

Program activities eligible for programming should aim to do the following: Increase access to services that improve the status and function of torture-affected individuals, their families and communities; improve quality of interventions for torture-affected individuals and communities through the study of impact of interventions; improve public awareness of the consequences of torture and specific actions that might reduce future incidents of torture; increase the capacity of organizations and individuals involved in delivering services to torture-affected individuals, their families and communities; and increase knowledge and dissemination of findings related to long-term improvement and function.

In addition to our country program, the fund is working with the Center for Victims of Torture (CVT) in Minneapolis, Minnesota, to strengthen the capacity of treatment centers both in terms of organizational viability as well as the delivery of services and advocacy of human rights.

Through this grant CVT is strengthening the capacity of 17 treatment centers worldwide, building clinical capacity among community treatment resources in Cambodia, and building the capacity of psychosocial workers to provide counseling services to torture survivors in Sierra Leone.

Additionally, the fund is working with Boston University and CVT to strengthen the evaluation and research capacities of our partners to enable them to measure the impact of their services.

In conclusion, the TVRA has been instrumental in the U.S. Agency for International Development's involvement in promoting and improving the quality of services for torture survivors worldwide. We continue to build on our past successes and strive to give survivors the support they need to reduce their suffering and rekindle their connection to everyday life. Thank you.

Mr. SMITH. Dr. Lockett thank you very much for your testimony.

[The prepared statement of Mr. Feinberg and Ms. Lockett follows:]

PREPARED STATEMENT OF MR. LLOYD FEINBERG, MANAGER, AND MS. DANUTA LOCKETT, SENIOR ADVISOR, VICTIMS OF TORTURE FUND, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

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2. Targeting individuals, who suffer reduced function due to direct or indirect exposure to torture, and communities with many such persons.
3. Building on existing community networks and resources.
4. Breaking the silence experienced by individuals and communities affected by torture.
5. Strengthening public response to torture in order to protect individuals against future incidents of torture.

Toward this end, the Fund administers treatment programs based in 30 countries that span four regions (Latin America and the Caribbean, Africa, Asia and Near East, and Europe and Eurasia). Currently, the Fund is overseeing a total of 27 agreements for treatment programs that include attention to the medical, psychological and social and needs of torture survivors and their families. Some of these programs include advocacy, training, technical assistance and research. Our 27 grantees are supporting another 99 local non-governmental organizations which are based in the communities where survivors live. This multiplier effect is one of the major achievements of the Fund as it strives to build the critical threshold of local services to support survivors as they seek to come to terms with the abuse they have suffered. The 2003–2004 Portfolio Synopsis gives a more detailed perspective on the Fund's programs. We are currently updating the information for a 2005 Portfolio Synopsis which we expect will be ready by early fall.

#### FUNDING GUIDELINES

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- Improve quality of interventions for torture-affected individuals and communities through the study of the impact of interventions.
- Improve public awareness of the consequences of torture and specific actions that might reduce future incidents of torture.

- Increase the capacity of organizations and individuals involved in delivering services to torture-affected individuals, their families and communities.
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In conclusion, the TVRA has been instrumental in the US Agency for International Development's involvement in promoting and improving the quality of services for torture survivors worldwide. We continue to build on our past successes and strive to give survivors the support they need to reduce their suffering and rekindle their connection to everyday life.

Mr. SMITH. Mr. Feinberg, did you want to add anything?

Okay. Let me just begin the questioning then and focus on the unmet need.

You know, traditionally we have authorized more than that which has been appropriated, and part of the fight there has been trying to demonstrate that this money would be spent wisely and is urgently needed. This year we will spend about \$8 million on overseas treatment centers and grants, and we would like to authorize, as you know, in our pending piece of legislation \$12 million. On the domestic side we have been spending about \$10 million per year and we would like to boost that to \$25 million and get real serious about beating this unmet need. I know it is not your expertise per se, but I know you certainly have feelings about it.

On the international level, how would you assess this unmet need? As my good friend and colleague, Mr. Payne, pointed out, there are a number of African countries where torture has been endemic and is a routine tool by dictatorships to punish and cower people into what it is they would like them to do. Please speak to the unmet need, if you could.

Mr. FEINBERG. Thank you, Mr. Chairman. And thank you for raising this important issue.

I think there are two elements that need to be addressed, and perhaps I can address one part of it, and maybe Dr. Lockett and I can try to address the second. The first part, of course, has to do with financial resources. We do realize that the agency has not been able to obligate the full amount that has been appropriated. This is a classic example of supply and demand, with increasing demands upon the agency, increasing numbers of other special needs that are identified by Congress and the Administration.

There is a huge demand on our limited resources, and I am afraid that the answer to the question from a financial standpoint is above my pay grade. But we certainly are trying to do our best to be able to demonstrate impact of our programs and to demonstrate the relationship between the impact of these programs and the reconstruction, rehabilitation of recovering economies.



In terms of finding ways to expand our ability with fixed resources to meet the unmet needs of the many people who require them, perhaps Danuta would have some ideas in that area.

Ms. LOCKETT. I think one of the challenges—it is not a limitation, but it is just to let you know one of the challenges we face in programming is finding people who are qualified in particular to attend to needs of torture survivors. In countries where—that have been stricken by political transition and conflict, it is has affected the NGO community and the professional community in their ability to sort of mobilize to provide the services. And our preference is always to work with local organizations, and where we can, we do so.

So I think that one of the ways to address this is really to improve some of the training that is certainly within the rubric of the TVRA, and it is an important component. We feel our success is ultimately whether we can leave behind organizations that can continue the work after we leave, and sometimes it is a matter of looking at systems of groups or networks of organizations both in the human rights sector as well as in the mental health and medical sectors that can actually address these needs as they go along.

So perhaps that is the first place one needs to start is to take a serious look at what is available in the country and to be able to program it responsibly.

Mr. SMITH. Let me just ask you a question on assessment. Is there an ongoing assessment or assessment teams that are looking at particularly war-torn areas or areas where there is a significant dictatorship, such as Zimbabwe and other countries where torture is a common staple?

Ms. LOCKETT. Well, we have a very large program, and have for a while, in Zimbabwe. It is not discussed specifically because the feeling was that it would draw attention to the organizations that are being served. So it is unmentioned.

But, yes, you know, I think that you will notice in the portfolio of countries where we are, I think that those are where great needs are. It is not to say it is all of the needs.

Mr. SMITH. Could I ask you, and this would be more for the record, knowing that we are going to be marking up a bill that would increase funding by \$4 million, how might that money be spent? Where have you and your colleagues, and Ambassadors and in-country teams obviously identified a need, but can only sit there and perhaps throw your hands up and say, if only we had the money? If you could provide that to us, it would be very, very helpful, because I have found so many times, whether it be on trafficking or any other issue that I have worked on, there is almost this one-dimensional myopic blinders on view that there is no absorption capacity. There is no real need out there. Nobody has come forward. We haven't looked. I am not talking to you, obviously; I am talking to some of my own colleagues. It is something that I think we need to make the case for more persuasively. If you could help us and provide that, we will make it a part of the record, and also use it to try to garner these funds.

[NOTE: The information referred to was not received prior to printing.]

Mr. SMITH. Can you also outline for us the process of establishing a new center? And are there any centers—whether they be almost like an out-patient clinic or an adjunct to an existing medical center—planned for 2005?

Ms. LOCKETT. In terms of centers specifically, if there is an established center, we make an effort to support it, but we don't necessarily limit ourselves to centers. If there are organizations that are in the human rights field who are providing protection, who are providing services that have the capacity, we try to build on that network as much as possible.

I think our biggest challenge is that, you know, these countries are very large and complex. People who often have been the most abused don't live in the capital cities. One has to think of effective delivery systems and how to reach them.

So, yes, where centers can be supported we certainly do, but where we think that services adjunct to the centers are appropriate, we certainly look at those alternatives as well.

Mr. SMITH. Are there any in the planning stages?

Ms. LOCKETT. No, not in terms of new countries, but in existing countries we have centers where we are supporting the centers.

Mr. SMITH. Is there any concern that those or the existings don't have enough funds to be sustainable? I know that is a concern that we have domestically, but you have that feeling, too?

Ms. LOCKETT. Yes. I think that it often depends on the capacity. Where we have supported the centers, I think that there is adequate funding. We have certainly encouraged centers to start looking at ways to decentralize some of their services where possible, and in a number of instances we have made that a suggestion for them to actually add funding for that purpose to go beyond.

But to my knowledge, of the countries where we are working, at the moment there are no new demands being made on this program for the centers, although as I said before to you, we are always very open to that dialogue, and I am not saying that we necessarily know everything that there is.

Mr. SMITH. Let me ask you, in countries like Turkey and Egypt where they have torture centers and where there is an ongoing effort by the government to intimidate physicians and other personnel at the torture centers, what do we do as a government? I am talking about our Embassies in Ankara and Cairo. Do they lend and assist, since we support these centers, and intervene with the governments to cease and desist their active intimidation, or, worse, campaign against the doctors who might testify against some police officer or some higher-up for the use of torture?

It seems to me that there ought to be sandbags across the torture centers as a place of respite and healing, but there is also a law enforcement component to this, because the information can be very useful in trying to get rid of a climate, as well as individual cases, where people are tortured. What are we doing there?

Ms. LOCKETT. As I mentioned before, in those countries, if there are centers that would like funding, we need to hear about them, but we haven't in those countries. Have we gone out and actually sought out the torture treatment centers there? We haven't as of this point, but it is not to say it is a limitation.

Mr. SMITH. Are there any countries where we have programs where physicians and medical personnel or any personnel are intimidated by the government not to come forward and support the action, for example, of a torture victim against the perpetrator of that crime?

Mr. FEINBERG. Not that we are aware of. I think a lot of these issues would probably be raised with an Embassy in the country as opposed to an USAID mission. And I think certainly if it was raised with the centers that we are supporting, it would be reported to us, and I have not heard this.

Mr. SMITH. Let me just ask one final question. Regarding our collaboration with the U.N. Voluntary Fund, when we first did the Torture Victims Relief Act in the late 1990s, the amount that was attributed was in the hundreds of thousands of dollars. It is now about 7 million actual appropriated dollars. They have a number of very, very important programs, and I understand other countries now following our lead are willing to provide additional monies. How do you interface with the U.N. Voluntary Victims of Torture? Do you cooperate on projects so that you do one, they do one, and you work together on the third? How does that work?

Ms. LOCKETT. No, we don't have a relationship established with the U.N. program.

Mr. SMITH. Do you think it would be advisable to?

Ms. LOCKETT. I think that would be a great idea. You know, I met recently with the new head of IRCT, and I think her relationship with the U.N. Voluntary Fund is good, and I think we can establish a stronger network. But it hasn't really happened up to this point, but I think it is a very good idea.

Mr. SMITH. I do have one final question regarding the collaboration with our own domestic centers. Writing that legislation could not have been done without their input and push and expertise. Does your office also utilize their expertise particularly in the training of personnel, best practices, if you will, so that they don't reinvent the wheel in country X, Y or Z? Are we doing that?

Ms. LOCKETT. We have met with two such centers, the program in Bellvue and also Scott Portman's group in Chicago, and in both cases where we have encouraged is that they have developed a relationship with particular organizations in the field because we were so decentralized and field-focused. We find that work—having that country presence makes all the difference. It is the difference between us telling people what to do and actually working through a group to sustain its capacity in country. So we have encouraged relationships overseas for those two centers and would do so with others as well.

Mr. FEINBERG. But certainly CVT is our major technical advisor and partner in providing this assistance.

Mr. SMITH. I understand.

Mr. Payne.

Mr. PAYNE. Thank you very much.

I wonder if you could sort of give us a sort of a picture of really what goes on at a treatment center. How do victims find out about the center? How is the location found? Is there like registration? Is it confidential? Does the country—I would imagine that a country would not be that comfortable with a center, you know, dealing

with people who have been tortured, because generally I guess it would be done by the officials of the country, and I wonder how all of that kind of works out.

Ms. LOCKETT. You know, every program is different, but if I could talk about, I think, a fairly large program in eastern Congo that deals with women who have been violated sexually because of the conflict, where rape has been used as a tool of war. We have set up four programs there that deal with both the medical, psychological and social, legal implications of what has happened, and those programs feature mobile clinics that go out into the community to find the women who have been affected.

It is not easy to get to the particular programs where they are being—where treatment is offered. Those who need it are given a medical sort of review of their needs and then linked to organizations that can provide with the specific set of services.

So again, this is an example of where we are not dealing with a single center; where we are dealing with a multiple set of programs that address sort of the full set of needs of survivors.

Similarly in Burundi we are working with four organizations, two of them local. One is Global Rights, the other one is Search for Common Ground. And one of the local organizations has a very strong reputation as a human rights group that actually knows where the victims live and through that provides the referral to the centers and the various treatments that are available. In cases where there are legal options, it is surprising, but both in Burundi and the Congo we have succeeded in getting some prosecution of cases or cases being admitted where violence has occurred, and there has been some prosecution followed.

In Nepal there is a very large center there. Its reputation is so solid, it has a radio program. It makes a strong outreach effort to get to the survivors as well.

I don't know if that answers your question, but I think that it is a critical need is to be able to make the linkages, absolutely.

Mr. PAYNE. So the center locations, they are known—I guess torture wouldn't only necessarily have to be at the hands of government officials, or even if it were done, maybe the government says it is not their policy, so that, for example, earlier, 20, 25 years ago, when, you know, the battered spouses syndrome started coming up, they would have homes in urban centers, but, you know, no one would know where they were except for the social worker so that they could prevent the—usually the female spouse from the abuser knowing where she and maybe the children were. And so it was sort of a safe house that was not known. But these centers are sort of where people—the agencies who deal with this know where to go pretty well.

Ms. LOCKETT. Yes, and also the protection element that you mentioned where there is safe houses. You know, in Haiti and Zimbabwe we do provide that for people who can't return back home, sort of immediate through emergency-level protection, almost medical attention where it is needed as well. And frankly, it is not easy to—for survivors to always report for treatment, particularly where the violence is very active. There is a fear of being labeled, of being identified. There are other kinds of concerns rather than just the mental health. So some of these programs are long

term, so we see, you know—we find that we need to be able to respond at both levels. But it is a very good point.

Mr. PAYNE. Great. Thank you very much. Thank you.

Mr. SMITH. Mr. Tancredo.

Mr. TANCREDO. Thank you, Mr. Chairman. Just one or two questions.

I would like to know more about the quality control, I guess, if I can use that phrase to describe the process. How do you know when a program is working? I mean, when you look at who you are going to provide funds to, which centers and that sort of thing that make application, I suppose it is on that basis, how do you know that whatever they are doing is the best practice?

Ms. LOCKETT. Well, that is exactly part of the problem that we face is there are many approaches often to treatment, especially in environments where the levels of trained individuals may not be as high as they could be, for very good reasons, because of the political transitions and violence. And so we have felt that it is really important to provide capacity to our parties to monitor and evaluate their programs and to be able to evaluate in terms of impact are people better at the end of the day as a result of the services. And this quality control is something that we are building more and more, both with the help of CVT and Boston University, where we are going out and training our grantees. So there is a level of technical assistance that we do to sort of beef up the capacity to monitor and evaluate programs.

Mr. TANCREDO. But it is fair to say at the present time then that the only thing we look at in terms of success is the number of people served?

Ms. LOCKETT. Yes. It has to go beyond that.

Mr. TANCREDO. It certainly does, but right now that is not the case.

Ms. LOCKETT. I would say that, no, we are taking a serious look at, I mean, where, for example, we just finished doing a workshop and hired a local organization in Guatemala to work with our 17 grantees to do just that, to be able to report on results not in terms of numbers. And that is the intent of the work that we are doing.

Mr. FEINBERG. I would just like to add the point that you are absolutely correct that what we do is look very closely at the end results and the impact of the actual interventions. At this point I think we are a little past the idea of just counting numbers, where we are looking at process. I mean, in terms of quality control you can either do process quality or product quality. We are certainly trying to move toward product quality, and right now I think we are mainly looking at process quality and looking at the way that organizations are providing services and the way that they do deal with the victims. But.

You are absolutely right. We do have to look, and we are devoting a lot of our resources to furthering the state of the art and identifying in a culturally appropriate way because every society, you know, has different criteria, you know. What is considered normal for us is not necessarily normal in other societies, and I think that a lot of our effort is in looking to try to find out in those cultures what constitutes normal functioning.

Mr. TANCREDO. As we approach this issue from a funding standpoint, I mean, of course, that is going to be a question I would imagine you will encounter more than once, and I think there is a certain degree of leeway that you give any program that is just starting out, any program of this nature, saying, well, you know, I understand that there is a great need. We know there is a need. We will try our best to address it. Right now we can't really get to the point of determining whether or not this particular program or even this particular treatment is better than something else. But I think this has been around now long enough that we have to actually begin looking very carefully at that so as to increase the appropriation based upon some assumption that what we are doing is working.

Ms. LOCKETT. I think one of the things that we have chosen to do is to use improvement in function and well-being as a marker. You know, at the end of the day are people better; are they better to assume the social roles that are expected of them and to really help their communities and families continue to recover?

Mr. TANCREDO. Right now, for instance, there is no time period for somebody. You can't be in a program for just a month or two or whatever, is there?

Ms. LOCKETT. You know, it is hard to generalize, but I think what we find is that there are sort of waves of when people are well and when they are not, you know. It isn't sort of a constant state of depression or not being well, but—so that there is often just a natural recovery period, so that it is not the kind of thing like a pill that you give somebody or put on glasses and you can see better.

You know, it is not an easy intervention, and it sorts of gets into some of the issues in the mental health field, which Dr. Heller, I am sure, is much more able to talk about than I am. But essentially what we try to do is identify the people who aren't functioning well and to bring services to them.

And what we need to do is improve our approach to identifying those people and to following up to make sure that they are better off. But the intervention might be a 13-week intervention. They may be better after that, but it could be a year later something triggers the response back, so it is often long-term mental health intervention that is needed. So there is not an easy answer, I guess.

Mr. TANCREDO. No, of course not. It is not an easy task for you to try to accomplish, and I commend you for being as judicious as you are.

One other thing is I notice that the other countries that presently contributed—29, are there? Yeah, 29 countries, 1,934,000. In any of the other countries, do you know—or I guess I will put it this way: Do you know of any of these countries that actually have laws like ours, programs like ours funded by the government, or is it just a sort of a random contribution thing that you get from a country at any point in time?

Ms. LOCKETT. I think that there are countries that sign on to the convention, but don't necessarily police it, if you will, or don't necessarily enforce it. And also there are often frameworks, judicial frameworks, that allow for torture, such as in Mexico where confes-

sions are widely accepted as evidence, and it has more to do with the legal structure in promoting torture, at least by police. So I don't know the direct answer to your question.

Mr. TANCREDI. I really was just asking about the dollar contribution, I mean, from other countries. Do other countries, to the best of your knowledge, actually have programs in law like we do, something similar to this?

Ms. LOCKETT. No, not that I am aware of.

Mr. TANCREDI. Okay. Thank you very much, Mr. Chairman.

Mr. SMITH. Ambassador Watson.

Ms. WATSON. I think Dr. Heller will probably be able to address my concern, and Representative Tancredi was leading to it, and I was wondering about the mental health treatment, because I think the physical wounds heal, but the emotional wounds tend to linger for a lifetime. And so I wondered how—do we have the personnel? Are we training those in these centers that are located in some of the most offensive countries, or most offending countries? Do we have personnel that could go over and train the health providers in mental health to be able to have a healthy outcome, both physically, emotionally and psychologically?

And so I think you have addressed it in part, and so I will wait until the next panel. If you want to comment, fine, but I will wait until the next panel.

Ms. LOCKETT. Well, for example, Mexico, we do have a relationship with the torture treatment center in Los Angeles where they come to do training, you know. It is spotty. I think it is definitely something that needs to be strengthened. And it is a big issue, you know; it is part of the challenge, I think, in doing this work.

Ms. WATSON. Well, I notice that in the larger bay areas in California, we have lost our public funding that comes through the Department of Health and Human Services during the last fiscal year, so it is going to make it harder for us, in the largest State of the Union—I always like to throw that in—to provide our expertise, say, in a center down in Mexico. So I will ask another panel to comment on that. I would really like to see our effort focus on the unseen, unhealed injuries. Those are emotional and psychological.

Mr. FEINBERG. Could I just offer one other quick comment?

Ms. WATSON. Please.

Mr. FEINBERG. USAID invests a lot of money for a long period of time in developing health systems, health delivery systems around the world in developing countries. This is a huge task. Very few developing countries have mental health capacity within their government services, and it is hard to get them to move forward on that position, especially when they have to make hard decisions in terms of their own available finances. But I think that that is certainly a subtext of what we are trying to do is trying to increase the awareness and appreciation of the necessity for mental health services within the general public health service delivery systems. And I think that the first step is developing a fertile ground with which to work.

Ms. WATSON. Well, let me just respond by saying that I think our efforts can go to helping them design systems that have a whole range of service for victims of torture, starting with the emotional.

And so I think that is where we can put some emphasis. And I will wait for the next panel, but thank you so much for your responses.

Thank you, Mr. Chairman.

Mr. SMITH. Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

I really don't know if I am going to ask some questions that probably I don't expect folks to answer. I am just going to state them out loud for food for thought for those of us in the Congress here.

The Chairman mentioned Turkey, and Turkey has put forward some parliamentary reforms and has really tried, to use a common vernacular phrase, clean up its act. But there is still significant problems in Turkey, and it goes all the way down to the local enforcement. The word hadn't gotten out. They have started to prosecute local enforcement people who have been involved in torture as they can find and as it is reported, but there is a lot of work to do. It is listed in our human rights report that they have five national treatment centers, so then those are funded somewhat by the national government or not? I mean, when it says "national," it doesn't say international treatment center. Are you familiar with the treatment centers in Turkey?

Ms. LOCKETT. I don't know the case in Turkey, so I can't address it directly, but there are funding sources often either through the EU, the Danish Government, that have been active in certain regions, so it may be the case they receive funding from other donors or governments.

Ms. MCCOLLUM. And in the report here it mentions that the EU is monitoring and not giving anybody a clean bill of health on that, that there is a lot to do. Part of what they are working on is having their medical personnel report torture. Do we work with governments in other countries of having—where we are funding centers, having things in law, working with those countries to identify medical personnel to report torture as they see it?

Ms. LOCKETT. It is not an active part of our existing programs, no.

Ms. MCCOLLUM. When reading through some of the torture that was described in Turkey, torture methods, they were concerned, human rights groups, that did not leave physical traces. The list here included repeated slapping, exposure to cold, stripping and blindfolding, food and sleep deprivation, dripping water on the head, mock executions. And is that a concern that has been discussed at a governmental level here, that in working with torture centers in other parts of the world that you provide funding to, that there needs to be ways to intervene and have people come forward who might not have physical traces?

Ms. LOCKETT. I think that that is absolutely right. Whether—I can't address whether or not our Government is actually moving to actively promote that, you know. At our level we are more sort of technically involved in the delivery of services, so that the question is an important one. I just don't have the answer to it.

Mr. FEINBERG. Those kinds of issues would have to be based through an Embassy, not through aid.

Ms. MCCOLLUM. Mr. Chair, I bring them up because I think at some point maybe we need to find out what we are doing in that area. It was very disturbing to me, Mr. Chair, to read this. And I



know you and I and other Members of the Congress had the misfortune, and I do mean the misfortune, of viewing what took place in a detention facility in Iraq that we were responsible for, and that describes many of the lists that I just—the sleep deprivation, the mock executions and that that were taking place. And I wish we were having a hearing to open that up so that other countries that you are working in, that we are working with, see that we are not afraid to confront the evils among us at times and do something about it and say never again.

Extraordinary rendition also, Mr. Chair, I think Turkey and Egypt also have been countries that have been listed, and I am very pleased that the House passed pretty much unanimously, I believe, to end that practice, because on one hand we are telling Turkey not to do this, we are working with the EU, we are putting dollars and resources into it, the government's trying to reform through its parliamentary procedures to end it, they are working with civil society, with the medical community, and then when we are participating in extraordinary rendition, we say, oh, but maybe it is okay under this circumstance. So I appreciate the answers that have been given, and I look forward to working with the Chair to get some more answers in the future.

Mr. SMITH. I thank Ms. McCollum. And I would just agree with her. One of the—I will never forget, I chaired a hearing of the Helsinki Commission back in the late 1990s, and it was focusing on torture in Turkey. And the next day the headline in the major Ankara newspaper was, State Department Defends Turkey Against Congress. And a bit of a paraphrase, but the whole idea was and the focus was on the ongoing use of torture there.

And your point on extraordinary rendition is very well taken. We don't—how did—Ed Markey kept saying we don't—what is the word for it—outsource torture. I mean, I think he coined the phrase. Maybe he is not the one that did it, but he used it enough. Torture is absolutely proscribed by the Convention Against Torture, and any civilized country should absolutely abhor it whether it is done by its own or anyone else. So I thank you for your comments.

I have one final question if I could. In Afghanistan and Iraq, there are many walking wounded who suffered horrible incarcerations in the case during the Saddam Hussein years of being put into tight spaces sometimes for years at a time and terrible tortures inflicted on them. Are there any plans for torture centers funded by the U.S. Government for those two? Any new plans in those two countries?

Ms. LOCKETT. The Kovler Center is working with the State Department on Iraq, and they have worked to at least address some of the mental health needs and how to approach it. Whether there is a specific center, I am not aware. But beyond that we don't have any immediate plans.

Mr. SMITH. If you could get back to us on that and whether or not such an initiative would be justified. Seems to me that it would be, and that is part of that information if you could convey to our Subcommittee as to why we need to increase the funding for this fund.

[The information referred to follows:]

WRITTEN RESPONSE RECEIVED FROM MR. LLOYD FEINBERG TO QUESTION ASKED DURING THE HEARING BY THE HONORABLE CHRISTOPHER H. SMITH AND THE HONORABLE BETTY MCCOLLUM

At this point, USAID does not plan to support the establishment of torture treatment centers in either Iraq or Afghanistan. Given the current lack of access, and the need for those conditions that such an initiative would require, it is USAID's position that we not support the establishment of centers at this time. The issue should be re-visited in a year to determine if conditions have changed sufficiently to warrant reconsideration.

It is important to note, however, that USAID has supported other forms of assistance in Iraq to victims of the brutality of the former Saddam Hussein regime such as enabling the documentation of crimes and facilitating the ability of victims to reveal their personal history, an important step in the healing process.

Ms. MCCOLLUM. Would the Chair yield? I am wondering if we could also include on that what the United States Government is doing to reach out to those people who are Iraqi citizens who were tortured in Abu Ghraib and other circumstances. We have a moral responsibility to reach out to victims of torture, but especially those that we had a hand in looking the other way and not stopping torture.

Mr. SMITH. If you could provide that as well, that would be helpful. Thank you.

[The information referred to follows:]

WRITTEN RESPONSE RECEIVED FROM MR. LLOYD FEINBERG TO QUESTION ASKED DURING THE HEARING BY THE HONORABLE BETTY MCCOLLUM

USAID has no current plans to attempt to identify Iraqi citizens who allege to have been tortured in Abu Ghraib or other circumstances. We are unable to comment authoritatively on what plans other USG agencies may have in this regard.

Mr. SMITH. I would like thank you so much for your testimony and look forward to hearing back from you about your great work on behalf of torture victims.

I would like to welcome our second panel beginning with Sheikh Sackor. Mr. Sackor is a survivor of torture from Liberia in 1997. He started an organization called Humanist Watch Liberia. As a result of speaking out for human rights and democracy, he was repeatedly imprisoned and tortured. Fearing for his life, he fled Liberia and came to the United States, where, in 2004, he was granted political asylum.

Thank you for your courage and willingness to be here today and to share with this Subcommittee your insights and your story.

We will then hear from Dr. Allen Keller, who is no stranger to this Committee or certainly to this issue. He has been a leader on this issue for years. He is Founder and Director of the Bellevue/ NYU Program for Survivors of Torture. This remarkable program is certainly sponsored by Bellevue Hospital, the Nation's oldest public hospital, and New York University School of Medicine, a leader in medical research and education. The program provides comprehensive mental health and social services to refugees and asylum seekers who have suffered from torture and other human rights abuses. Dr. Keller is also Chair of the Policy Committee of the National Consortium of Torture Treatment Centers, which includes 35 organizations in 21 States dedicated to advancing the knowledge, technical capabilities and resources devoted to the care of torture survivors, and collectively to prevent torture worldwide.

Finally, we are joined by Douglas Johnson. Mr. Johnson has been Executive Director since 1988 of the Center for Victims of Torture, the oldest torture treatment center in the United States. CVT provides comprehensive care for victims of government-sponsored torture, conducts research and training, and undertakes policy efforts such as he did when we wrote the first Torture Victims Relief Act to commit the United States and other institutions to work against torture and to tangibly aid torture survivors. Mr. Johnson also serves as an original member of the Organization for Security Cooperation in Europe, which was established in 1998, and has testified before the Congress many times.

Mr. Sackor, if you could begin.

**STATEMENT OF MR. SHEIKH SACKOR, FOUNDER, HUMANIST WATCH LIBERIA, SURVIVOR OF TORTURE IN LIBERIA**

Mr. SACKOR. Thank you, Mr. Chairman and Members of the Subcommittee. I am honored to be with you today, and I thank the Subcommittee for holding this important and timely hearing on the Torture Victims Relief Act. Today I speak to you as someone who has directly suffered from the brutality of torture, as someone who has benefited enormously from the assistance of a torture treatment program funded by the Torture Victims Relief Act: The Bellevue/NY Program for Survivors of Torture.

It is not easy to talk about what I have suffered, but I think it is important that you hear first-hand the brutality that is torture. In my native country of Liberia, in 1997, I founded Humanist Watch Liberia, which advised my fellow Liberian citizens on their civil and political rights. I frequently spoke out against human rights abuses by the regime of Charles Taylor. As a result of my peaceful political activities aimed at promoting human rights and democracy in Liberia, I was imprisoned and brutally tortured by the agents of the government. While being interrogated, I was beaten all over my body. I was repeatedly shocked with electric wires. My interrogators kept accusing me of being an anti-government agent. They would shout at me, "You are anti-government, and we will one day kill you." They also tried to force me to sign a retraction of a statement I made against the government. When I refused to sign, I was again brutally beaten.

Thanks to the pressure from the religious and human rights organizations, I was freed; however, I continued to be threatened and harassed and lost my job at the National Social Security Office owned by the government.

I continued to speak out against human rights violations and was again tortured and imprisoned, including one imprisonment for almost a year. In gaining my release from this last imprisonment, I was greatly assisted by the United States Embassy in Liberia.

Continuing to fear for my safety in 2003, I fled from Liberia and came to the United States where I applied for political asylum. Subsequently, I learned about the Bellevue Hospital Program for Survivors of Torture. Before receiving care from this remarkable program, I felt so depressed and hopeless. I was in terrible pain physically and emotionally. My back and muscles hurt from all the beatings I had endured. I could not sleep. I felt frightened and so alone. I could not stop thinking about what I had suffered.

The Bellevue/NYU program provided me with the help and support. They gave me medical care to assist with the back and muscle aches I had. I was seen by an eye specialist to address the problems that I had, I believe, as a result of being beaten, blindfolded and kept in the dark. I saw a skin doctor who helped to make the scars from my torture less visible. I also received mental health care, including medication for several months to help me sleep and feel less sad and nervous.

I also participated in an African torture survivors group that the program sponsors. This made me feel less isolated. Doctors from the program wrote an affidavit for my asylum application in 2004. I was granted political asylum.

The Bellevue/NYU program has become like a family to me. The program provided me with clothing and food. They also helped me to find a job. Now I am working at the Federal Reserve Bank of New York. This program helped me regain and rebuild my life.

Mine is a story like so many other individuals around the country cared for by the torture treatment centers funded by the Torture Victims Relief Act. But I know from my fellow torture victims now living here in the United States that the need for more services is enormous. I urge you to do whatever you can to increase funding for the centers doing this important work. For survivors of torture, this is truly a matter of life and death. I thank you.

Mr. SMITH. Thank you so much for your testimony.

[The prepared statement of Mr. Sackor follows:]

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I urge you to do whatever you can to increase funding for the centers doing this important work. For survivors of torture, this is truly a matter of life and death. Thank you.

Mr. SMITH. I just note that if Greenspan were here testifying, this place would be packed with the media. But for somebody who is obviously very courageous and stood up against tyranny and works for the Federal Reserve, we have one man from the press.

Thank you for being here. Thank you for your testimony.

Dr. Keller.

**STATEMENT OF ALLEN S. KELLER, M.D., DIRECTOR, PROGRAM FOR SURVIVORS OF TORTURE, BELLEVUE HOSPITAL CENTER, NEW YORK UNIVERSITY SCHOOL OF MEDICINE**

Dr. KELLER. Thank you, Congressman Smith, and thank you to the Committee. It is an honor to be here today. I want to—I am humbled to sit between two extraordinary colleagues, Doug Johnson, who I view as a visionary in this field and a friend and a mentor, and a patient individual we have had the privilege of caring for, Sheikh Sackor; truly heroic, and who on a daily basis doing this work reminds us of why we do this.

And then to you, Congressman, thank you so much. To those of us doing this work in our program, to my colleagues in the consortium, to the patients we serve, you are truly a hero. And to the Members of this Subcommittee and the original sponsors and co-sponsors, we are so grateful. And we also know that so much of the work gets done by the staffers, many of whom—familiar faces I see here, Erica and Hans and others. And I believe this issue clearly does speak truly a bipartisan—the best of a bipartisan effort. And I hope the markup will reflect that better side.

So as you mentioned, the Consortium of Torture Treatment Centers consists of 35 organizations in over 21 States, and these programs really provide diverse models of care, medical, mental health and social services. Some are freestanding; some, such as our program, are housed within medical centers and hospitals; others within community service organizations. And reflecting the newness of this field, almost all are less than 10 years old.

Our program, which was founded in 1995, is jointly sponsored, as you mentioned, by NYU and Bellevue Hospital. And thanks to the support from TVRA, our program has undergone extraordinary

growth. Before TVRA—we were founded in 1995—I guess we were seeing between 50 and 100 patients. And then following the funding from TVRA, the number increased dramatically. And tragically, the world being what it is, we get at least 10 requests for referrals a week. And last year alone, we cared for more than, I believe, 700 individuals from over 70 countries.

As you mentioned, torture is a worldwide health and human rights concern documented in over 100 countries, and there are estimates there may be as many as half a million or more of survivors here in the United States. Those survivors include students, religious leaders, political activists such as Sheikh.

One patient that I have cared for, a fellow named Samten from Tibet, he is a gifted painter, one of the leading artists in Tibet. He was arrested and imprisoned because he wrote poetry critical of the government there. And after he was imprisoned, his Chinese interrogators said to him, you are not doing anything good with your hands, and so they thrust his hands into a coal-burning oven. He was beaten, knocked over the head unconscious, and he woke up in a dark cell. He was able later to somehow get released and then fled the country when he learned the authorities were looking for him. He eventually made his way to our program, and when he did, he suffered—was suffering from the severe burns. He could barely hold a paint brush, and when he did, in fact, his hand would tremble, and he would start to get these terrible nightmares.

So as the Ambassador was saying in focusing on the mental health issues, I think it is crucial. And it is crucial to appreciate—I view the health needs as really interrelated. It is hard to say where the physical ends and the psychological and the social begins. It is all interdependent.

So Samten had these terrible physical deformities. When he would go to hold the paint brush, that would result in these horrible nightmares. That then resulted in feelings of social isolation and mistrust. When we saw him, he actually hadn't slept, I think, more than 3 consecutive hours in 1 night.

So there was fortunately a lot that we were able to do for him. We provided him with general medical care. He and so many of our patients had been exposed to tuberculosis. Many of them have active TB because they have been held in dirty and overcrowded cells. We referred him to a hand specialist, who actually performed hand surgery, and he is now able to paint and is actually making a living at what is his life's calling.

In our program, we use a lot of groups. We found groups are extraordinarily powerful at helping individuals heal and reconnect. Over and over what I hear from the survivors that I care for, I say, "How are you different now than compared to before?" They say, "Before I was very outgoing, and now I keep to myself and I don't trust." So we use a lot of support groups. So we have a French-speaking African group and an English-speaking group that Sheikh has participated in. We have a Tibetan group. We have used women's groups. And we find the groups are very powerful.

Our program staff also prepare affidavits for individuals seeking asylum, and I am happy to say that Samten was recently granted asylum.

Torture can have these devastating physical and psychological circumstances. I have seen the scars from shackles, the marks from cigarette burns, the wounds from beatings, and also listening to the fears and feelings of shame and humiliation, and it is absolutely true that those psychological symptoms can be more damning and long-lasting. When a gun is held to someone's head and the trigger is pulled in a mock execution, there are no physical marks, but the nightmares truly can go on.

So what torture really does, it tries to undermine an individual's sense of trust and sense of safety. What I believe our program and all the members of the consortium try to do is restore that sense of trust and safety. One patient I cared for said something to me, she said, "For a long time I felt so alone, but after I came to your program, I again felt part of society." And this is what I hear from my colleagues from all over the country.

And as I mentioned, you know, before the TVRA, there were a handful of centers. We had limited services. After TVRA, the number of services increased dramatically. We estimate that in fiscal year 2004, the centers around the country cared for over 5,000 individuals.

Additionally, these programs serve as invaluable training and resource centers. We train current and future health professionals. I am happy to have a student and future colleague of mine, Joseph Shin, who is a second-year med student. And many of the centers around the country train the next generation of health providers. So much more added value than just the patients we are seeing.

And then doing a lot of outreach, both domestically and, I think, as so powerfully pointed out by the last panel, internationally and giving us the opportunity to share what we learned here, but the demand far exceeds our ability to provide services. Many centers, including our own, have significant waiting lists, and quite often in our program, that list goes on for months.

TVRA was initially authorized and appropriated at the level—at approximately \$10 million, unfortunate for the domestic programs, and unfortunately that is where it has remained. And what this has meant is hard and unfortunate choices have had to be made. Last year, as you know, the Office of Refugee Resettlement sponsored a new request for proposals, and we are grateful for ORR's leadership and vision on this.

On a positive note, there were programs in several places in the country where there was a need for this where new centers were found, in Miami, Atlanta and Salt Lake City. But sadly and, I would argue, truly tragically, many of the existing programs, including our own, because of funding limitations faced marked decreases in funding. As was noted, several programs across the United States, particularly in North California, were entirely defunded. Thus, instead—for our program, instead of looking to our expand services to meet the growing needs, many programs had to make hard choices about budget cuts, staff layoffs or even having to close. Again, a tragedy for the survivors benefiting from our services as well as undermining the capacity and the sustainability of many organizations with just this wealth of talent. For our program, what this meant was instead of wanting to grow as we could and were able to increase our capacity, we had to go into survival

mode, and for several months we actually stopped taking new clients.

I will say during that time I remember I was holding the letter from ORR in my hand and finding out we had been cut by \$250,000, and there was a woman from Sierra Leone, and it was on a Friday afternoon. I don't know if this is how it works in Congress, but in medicine, things always go bump at around 3 o'clock on a Friday afternoon. A woman was sitting outside my door and said, "A judge told me to come and see you." She had been applying for asylum, and in the middle of the hearing, she broke down and couldn't tell her story. She said, go to Bellevue. And she found our program. At first I said, unfortunately—and we just had a meeting earlier that day saying we really can't take new clients. I said, right now we are just taking a waiting list. And then she said, please. And I said, well, let me see if there is some other place I can refer you, and she squeezed my hand. And by the end, she had an appointment on Monday, and we did provide care, and she is actually doing amazing. She was granted asylum and working again and attending the group. We said yes to her, and I feel terrible for all those we weren't able to care for.

So I hope that these budget cuts can be restored and that, in fact, there can be growth rather than having us in survival mode. So in order to meet the needs of tortured survivors, I plead with you to support the increased levels of authorization on behalf of our programs and more urgently on behalf of the patients we care for. Our programs assist those so brutalized and traumatized and enable them hopefully to heal, to function and to thrive as new members of our great American society.

So, in closing I would say certainly in my work, in my daily work with tortured victims, I am reminded of the darker side of humanity and real potential for cruelty. I am reminded of the extraordinary resilience of the human spirit. And so I think it is in that spirit we need to commit ourselves to speaking out against torture, to providing adequate care for those who have suffered from this brutality and doing what we can to end this assault on human dignity. Thank you.

Mr. SMITH. Thank you so much, and we will get you some questions momentarily. Thank you for your leadership.

[The prepared statement of Dr. Keller follows:]

PREPARED STATEMENT OF ALLEN S. KELLER, M.D., DIRECTOR, PROGRAM FOR SURVIVORS OF TORTURE, BELLEVUE HOSPITAL CENTER, NEW YORK UNIVERSITY SCHOOL OF MEDICINE

Good afternoon. On behalf of the Bellevue/NYU Program for Survivors of Torture and the National Consortium of Torture Treatment Programs, I am honored to speak before you today. I want to thank the Subcommittee for holding this hearing, and a special acknowledgment to Congressman Chris Smith. Your leadership and tireless efforts on behalf of torture victims around the world, including those who have fled to this country to seek safety and rebuild their lives is profoundly appreciated. To me, to my colleagues at our Program and in the National Consortium, and to the torture victims we have been able to care for thanks to your support—you are truly a hero. We also owe much gratitude to the other original sponsors, and co-sponsor of the Torture Victims Relief Act—truly a bipartisan effort—, and to all the Congressional staff for their continued efforts on behalf of this legislative milestone. We are grateful to the Office of Refugee Resettlement who oversees disbursement of funds through TVRA for torture treatment programs in the United States.



The National Consortium of Torture Treatment Programs consists of 35 organizations in 21 states. These remarkable programs provide diverse models of care—medical, mental, health and social services. Some are free-standing organizations, others are based within larger Community Service Organizations. Reflecting the newness of the torture treatment movement, almost all of these programs are less than ten years old. Our program, which was founded in 1995 is jointly sponsored by New York University School of Medicine and Bellevue Hospital, the nation's oldest public hospital. We provide comprehensive medical, psychological care and social services to victims of torture and refugee trauma.

Thanks to support from the Torture Victims Relief Act, our program during the past several years has been able to care for over 1,500 men, women and children from over 70 different countries. Last year alone, we cared for over 700 individuals.

As you know, torture is a worldwide health and human rights concern, documented to occur in over 100 different countries. The need for assistance for Torture Victims now living in the United States is enormous. It is estimated that more than half a million survivors of torture, who fled persecution in their native countries, now live here in the United States. Survivors of torture arriving in this country include students, academicians, religious leaders and political activists. Anyone daring to question the ruling powers.

One patient I care for is Samten. He is a gifted painter and was a leading artist in Tibet. He was arrested and imprisoned after writing poetry critical of the government. He was brutally beaten, and then during an interrogation session, he was told that he “was causing nothing but trouble with his hands” which were then forced into a coal oven. He suffered severe burns with significant scarring/disfigurement of his hands. He could barely hold a paintbrush and when he did, he had terrifying flashbacks of his abuse. He also had profound feelings of sadness and hopelessness. He was sleeping only 2–3 hours a day, and even this sleep was interrupted by nightmares. At the time of referral to our Program he did not have a regular place to stay. Through our Program, he received primary medical care including pain management, treatment for exposure to tuberculosis as well as referral to hand specialists and subsequent hand surgery. He was treated with antidepressant/anti anxiety medication with significant relief from his symptoms. Social service staff assisted him in finding housing and also a pro bono attorney to represent him in his asylum case. Program staff prepared medical affidavits documenting his injuries. He also attended a support group for Tibetan survivors which helped him to restore important social connections. Following surgery, he had marked improvement in the use of his hands. Recently, he was granted asylum. He is again drawing and able to support himself.

Another patient, who for reasons of privacy I will refer to only as “Jenny,” was a professor at a leading university in her African country and was arrested for her work promoting human rights. While imprisoned, she was beaten, raped, and forced to stand for hours each day without moving. After her release, she escaped with only one of her four children to the U.S. On initial evaluation at our Program, she suffered from nightmares and constant worry, but her most immediate complaint was the painful swelling in her legs that persisted since her detention. Jenny was subsequently treated for deep vein thrombosis (clots) in her legs. Program staff helped Jenny and her daughter find temporary housing. She received individual/group psychotherapy and medications for depression/anxiety. Staff found her a pro bono lawyer who successfully represented her in asylum application. Jenny and her daughter now live independently. Her physical and psychological health is much improved. Our social service staff worked with Jenny to help her locate her other children, who were in a refugee camp, and earlier this year, Jenny was reunited with them.

Torture can have devastating physical and psychological consequences. I have seen the scars from shackles, the marks from cigarette burns inflicted during interrogation and the wounds and broken bones from severe beatings. I have listened to stories of shame and humiliation, of haunting nightmares, and memories that will not go away. One patient of mine, for example, who was repeatedly submerged in a vat of water while being interrogated, would feel like he was gasping for air whenever he showered or went out in the rain.

What torture does is attempt to destroy an individual's dignity and their sense of trust. What our program and the other treatment centers try to do is to restore to torture survivors their dignity, restore their sense of trust, help them heal physically and psychologically, and assist them in getting on with their lives. One of our patients, a woman who was repeatedly raped after attending a peaceful demonstration once told me, “For a long time after what I suffered, I felt so alone.” But your program made me again feel part of society. Patients who have received care in our

program and the other torture treatment centers are now working, going to school and again leading productive lives.

Before the Torture Victims Relief Act (TVRA), there were only a handful of centers around the country caring for torture victims. Thanks to the funding under TVRA, starting in 2000, the number of centers increased significantly. We estimate that in FY04 these centers served over 5,000 clients. Additionally, these programs serve as invaluable training and resource centers in their communities, across the country, and internationally. We train current and future health and social service providers. We conduct research on the health impact of torture and effective means for caring for torture victims. In addition to work in our own communities, many U.S. torture treatment centers are now sharing their expertise in assisting victims all over the world.

But presently the demand for our services far exceeds our ability to provide services. Many centers, including our own, have significant waiting lists. Quite often, the waiting list for services in our Program is for several months. Presently, in many areas of the country there are no centers, although there are tremendous demands for ones.

TVRA funding was initially authorized and appropriated at a level of approximately ten million dollars annually for domestic programs, with the expectation of increased funding each year. In FY05, funding was authorized at a level of 20 million dollars. Unfortunately funding has remained at the initial level.

What this has meant is hard and unfortunate choices have to be made. Last year, the Office of Refugee Resettlement sponsored a new request for proposals. On a positive note, several new programs around the country, including in Miami, Atlanta and Salt Lake City, were funded. But sadly, and I would argue tragically, many of the existing programs, including our own, because of funding limitations, suffered marked decreases in funding. Several Programs across the United States, and particularly in Northern California, were entirely defunded. Thus instead of looking to expand our services to meet the growing need and demand, many Programs had to make hard choices about budget cuts, staff layoffs, or even having to close. This is nothing short of tragic for the many survivors benefiting from or awaiting care at our centers, as well as undermining the capacity and sustainability of many organizations with extraordinarily talented and dedicated staffs just getting started.

For our Program, what this meant was that for several months, we had to stop taking new patients. While we were able to identify other sources of funding to get us through the year, these cuts threw us into survival mode, rather than where we had hoped and planned to be: namely expanding our services and outreach. The impact of these cuts still resonates through our Program's growth and stability.

In order to meet the needs of torture survivors throughout the United States, I urge you to support the increased levels of authorization and appropriation called for in TVRA. Our programs assist those who have been so brutalized and traumatized, enabling them to heal, to function, and to thrive as new members of our great American society.

In our work with torture survivors, we are reminded of the darker side of humanity and the potential for cruelty in this world. But we are also reminded of the extraordinary resilience of the human spirit. It is for the sake of all of those who have suffered from torture or continue to face risk of being tortured, that we must commit ourselves to speaking out against torture, to providing adequate support for caring for those who suffer the physical and emotional scars of its cruelty and to ending this assault on human dignity.

Thank you.

Mr. SMITH. Mr. Johnson.

**STATEMENT OF MR. DOUGLAS A. JOHNSON, EXECUTIVE DIRECTOR, CENTER FOR THE VICTIMS OF TORTURE**

Mr. JOHNSON. Thank you, Mr. Chairman and Members of the Committee. I would like to salute all of you who decided to be on a Subcommittee overseeing human rights. I can't imagine it gives you a lot of constituency approval at home, and takes a special person, a certain amount of bravery and a great focus on values to be here. So we thank you for the attention you put on this.

As you noted, CVT was very involved in the creation of the Torture Victims Relief Act, working with your staff in particular. And

I remember conversations with your staff as we thought how it should be administered. We often said what we need at AID is a Lloyd Feinberg to oversee the program. And the fact that we got the Lloyd Feinberg, not a Lloyd Feinberg, is a great pleasure for us despite the fact that I have a certain critique for how AID is administering the program.

I think they have to do with a question of strategy, and the strategy is a tension—the strategic question is the tension I feel today in the questions coming from you and our response, because in the end, in my view, it is really not morally troublesome to weigh whether a tortured survivor should receive treatment at Bellevue or in Atlanta or somewhere else. Each one is deserving. And there are limited number of resources. But I think the tragedy of the decisions that had been recently made is that it interrupted the creation of capacity. It interrupted a very valuable treatment center that was on the verge of producing knowledge in the field that could extend our work, that could answer many of the questions that Mr. Tancredo rightfully asked. And it is the decision often to look at how do we expand numbers rather than looking at where do we expand knowledge in the field.

In my view, the Torture Victims Relief Act was written as a strategy to create capacity, and that is what is needed now in this new field, and that is what I really want to speak to. There is, however, an increasingly and misguided view that torturous purpose is to gain useful information. Twenty years of working with torture survivors and studying the systems that produce them proves that this is not so. Torture is fundamentally a political weapon used by repressive regimes to shape cultures through fear, and part of our response, therefore, is not only how do we work with individuals, but how do we also gain the tools to reshape those cultures through healing and in support of democratic cultures.

We know that repressive regimes target the leadership of the opposition to destroy emerging movements that may threaten a corrupt regime's hold on power. Most of our clients tell us they said anything their torturer wanted them to say just to get it stopped. For this reason we believe that torture is the most effective weapon against democracy. The impact of torture will be felt for years, even after a regime has fallen; leadership is broken and lost, families and communities are too frightened to engage in public life, and there is a profound lack of trust in public institutions, the police and the courts.

As our Nation spreads the message of freedom and democracy, we would do very well ourselves to understand and to heal the legacy of torture, or our efforts to build democratic institutions will fail. We believe that the original sponsors of the Torture Victims Relief Act understood this connection and sought a new tool to help it build democratic societies through the strategic investment in torture rehabilitation programs around the globe.

The funding of TVRA was always too modest to provide care for even a small fraction of the total number of torture survivors. The need is tremendous, and the resources are limited. But rather, Congress saw the need to assist those already working in the field of torture rehabilitation to build capacity and expertise rather than create new organizations that essentially had no experience in the

field. It was to reinforce those who already were committed and were working. This investment would allow treatment centers to develop stability, attract highly qualified people, and build their knowledge base so they could become experts in the emerging field. With capacity and expertise, these centers could broaden our approach to torture treatment and prevention, including training mainstream providers, tailoring their program to the culture and circumstances under which they operate, and developing innovative new and effective approaches to ending torture, one of the world's most egregious human rights abuses.

In my written testimony, I give you many other examples of how this has happened. I have shortened it up considerably. You might not believe it as I finish. But those—I would invite you to take a look at those. What we know is foreign treatment centers have attained some level of organizational stability and expertise, and they are showing innovation and results that leverage TVRA in exactly the way Congress intended. While I discuss some of the barriers we face, there are also examples that show that the strategic investment of these centers has been very productive.

First, establishing and sustaining foreign treatment centers is difficult as it is necessary. In countries where torture is or has been practiced, the governments would prefer not to have a treatment center, as this means health professionals and human rights activists are confirming that torture is practiced. TVRA support through USAID and the U.N. Voluntary Fund for Victims of Torture is a critical political, moral and financial pillar to these treatment centers.

We have learned that TVRA funding plays a significant role in the prevention of torture. Often the services they provide extend well beyond torture rehabilitation to include forensic documentation; written and verbal testimony to courts and legislatures; advocacy for the rights of brutalized ethnic, religious and minority groups; and organizing in the public. Take, for example, our partner in Kenya, the Independent Medico Legal Unit, provides information to the Parliament about the incidents of torture in that country's police stations and prisons, and forensic evidence to its courts. In turn, the opposition uses the information to challenge the government to improve its human rights record.

I know that we hope Congress will continue its strong support for the voluntary fund by authorizing and appropriating an \$8 million contribution to the fund, and I would welcome questions about what other countries are doing in support of the fund, as Mr. Tancredo had asked earlier.

With TVRA support, CVT has initiated a long-term research study to explore the effectiveness of various types of torture, treatment strategies across populations, cultures and context. This ambitious study should in time result in improved interventions that maximize U.S. taxpayer investments.

While much good has been done overseas with TVRA support, several challenges remain. There are, of course, many areas of the world where torture survivors have little or no access to treatment services, including countries of the former Soviet Union, most countries in the Middle East, including Afghanistan and Iraq, and many countries in Africa. But there are other barriers to TVRA's

effectiveness, primarily the tendency among large institutional donors, such as the United States Government, European Governments and the U.N., to assume that it is better to spend \$10,000 to treat 1,000 people broadly defined as war traumatized rather than spending the same amount to treat 100 people who have been tortured because it somehow represents more bang for the buck. This approach to development assistance encourages NGOs to do only the minimum necessary to get State Department or USAID funding. Rather there should be an emphasis on developing an in-house wealth of knowledge that can be shared with the donor contributing to the worldwide torture treatment and prevention movement, and leaving behind well-established indigenous capability in the country of program implementation.

There is little support in the research literature for the effectiveness of many of the broad-scale psychosocial programs. By my calculation, less than 40 percent of earmarked TVRA funds channeled through USAID since 2001 have been spent on programming; that is, to use the legislation's own language: "In the form of grants to treatment centers and programs in foreign countries that are carrying out projects and activities specifically designed to treat victims of torture for the physical and psychological effects of torture." That intent was further clarified by the House Committee on Appropriations in 2003, which stated: "Supporting treatment centers as permanent national institutions is the best way of providing treatment centers to victims of torture and advocating for the elimination of torture globally."

We at CVT think indigenous treatment centers for victims of torture are the most effective way to accomplish both objectives, and while the percentage is increasing, we believe there is still a long way to go. USAID's requirement that agencies implementing programming overseas with their funds obtain a 25 percent non-U.S. Government match is a significant barrier for organizations with expertise in torture treatment and prevention, the vast majority of which are very small. If this barrier was reduced, eliminated, or at least temporarily waived for a certain period of time for organizations below a certain size, that would help all of us to focus on the work of expanding services and knowledge about torture.

This problem of trying to distribute a small amount of money as widely as possible also beleaguers the use of Torture Victim Relief Act money domestically. With TVRA, Congress intended to strengthen key regional treatment centers where knowledge could be created and leveraged into projects that would influence health care, human services and political assistance within their spheres of influence. Although the Office of Refugee Resettlement understood many of these concepts, there was a decision early on to encourage programs in many congressional districts rather than to concentrate funding into those centers most likely to create knowledge and expertise in the field. Groups completely new to the field with no previous experience received grants similar to those who had been laboring in the field as their primary mission for many years. Nonetheless in those first 4 years of funding, substantial capacity was built, including clinical expertise and treatment capacity.

Last year, however, ORR moved significantly away from the priorities it established in 2000. Twenty-six projects were funded, including eight new programs on no new funding. That meant six projects that had received previous support were not renewed. Of those six unfunded programs, two closed their operations immediately, and those are two organizations that never had a treatment purpose before, but only entered with TVRA funding. The others who did have a previous commitment scaled back their operations substantially. There are also, of course, centers like CVT and Bellevue that lost substantial amounts of their funding, but did not lose it altogether.

We witnessed a new phenomenon also in the funding program, support for governmental entities, which we had not known was contemplated by the authors of TVRA.

It is important to understand the consequences of not renewing the grant to an established rehabilitation organization like Bellevue. It meant that clinical and organizational capacity that had been dearly bought and invested, was, in fact, then lost. Torture victims who had been receiving care had nowhere else to turn to. But it also seems an unwise use of Federal resources to invest millions and then eliminate funds and cause programs to shut down or dramatically scale down right when they are on the verge of being able to make that broader contribution to the capacity of the movement.

We hope that in the future ORR will give greater weight to experience in caring for torture survivors and resist the urge to reach as many congressional districts as possible. And at least until significant new funding is appropriated, we hope ORR will not give additional weight to proposals that come from regions of the country that simply are without existing treatment centers because no one in the past has stepped forward to do it.

I would like to leave with one final example to illustrate how TVRA financial support can be leveraged to do much more to prevent and treat torture. In Bulgaria, the Assistance Center for Torture Survivors is using its expertise to also build and leverage collaborative partnerships for torture prevention training to the police officers of Bulgaria. The program creates a pool of trained officers who are in turn able to train their colleagues when they return to their own regional police directorates. The training is pragmatic, fostering changes in attitudes and behavior while giving police organizations and management the knowledge to successfully train their colleagues.

As you consider reauthorization of TVRA, I hope you will keep in mind that torture treatment centers like IMLU in Kenya, the Assistance Center for Torture Survivors in Bulgaria, NYU/Bellevue are leveraging a relatively small amount of financial support in creative, effective ways to heal the wounds of torture and to prevent torture. I believe this is the intent and I hope will be the legacy of the Torture Victims Relief Act.

[The prepared statement of Mr. Johnson follows:]

PREPARED STATEMENT OF MR. DOUGLAS A. JOHNSON, EXECUTIVE DIRECTOR, CENTER FOR THE VICTIMS OF TORTURE

Thank you for the opportunity to testify before you today and for the committee's consideration of the reauthorization of the Torture Victims' Relief Act.

## TORTURE: A POLITICAL WEAPON

There is an increasingly and misguided view that torture's purpose is to gain useful information. Twenty years of working with torture survivors and studying the systems that produce them proves that this is not so. Torture is fundamentally a political weapon used by repressive regimes to shape cultures through fear. Repressive regimes target the leadership of the opposition to destroy emerging movements that may threaten a corrupt regime's hold on power. They use torture to send fear through that leader's family and community of followers and admirers. They destroy leaders and send them back to their communities, broken and depressed, as an example to others. Most of our clients tell us that they said anything their torturer wanted them to say to make the pain stop.

For this reason, torture is the most effective weapon against democracy. The impact of torture will be felt for years, even after a dictatorial regime has fallen: leadership broken and lost, families and communities too frightened to engage in public life; and a profound lack of trust in public institutions, the police and courts. As our nation spreads messages of freedom and democracy, we would all do well to understand and to heal the legacy of torture, or our efforts to build democratic institutions will fail.

## TVRA: OVERCOMING TORTURE'S LEGACY

We believe that the original sponsors of the TVRA understood this connection and sought a new tool to help build democratic cultures, through the strategic investment in torture rehabilitation programs across the globe. The funding of TVRA was always too modest to provide care for even a small fraction of the total number of torture survivors. The need is tremendous and the resources are simply too limited. Rather, Congress saw the need to assist those already working in the field of torture rehabilitation to build capacity and expertise, rather than create new organizations with no experience. This investment would allow treatment centers to develop stability, attract highly qualified people and build their knowledge base so they become experts in the emerging field. With capacity and expertise, these centers could broaden their approach to torture treatment and prevention, including training mainstream providers, tailoring their program to the culture and circumstances under which they operate, and developing innovative new and effective approaches to ending torture, one of the world's most egregious human rights abuses.

Foreign treatment centers face many challenges. But those with TVRA support that have obtained some level of organizational stability and expertise are showing innovation and results that leverage TVRA in exactly the way Congress intended. So while I'll discuss some of the barriers we face, I offer several examples that provide a window to the potential impact of TVRA when used strategically to invest in torture treatment centers. Later I will briefly discuss how this same strategy could be used to leverage TVRA funds domestically.

## FOREIGN TREATMENT CENTERS: LESSONS LEARNED

First, establishing and sustaining foreign treatment centers is as difficult as it is necessary. In countries where torture is or has been practiced, the governments would prefer not to have a treatment center, as this means health professionals and human rights activists are confirming that torture is practiced. With rare exception, the host government is unlikely to provide any financial support to indigenous treatment centers, even though they are obligated to do so under the Convention Against Torture. It may even consider the center and its clients as a threat to its national security and therefore attempt to suppress or close it.

TVRA support through USAID and the UN Voluntary Fund for Victims of Torture is a critical political, moral and financial pillar to these treatment centers.

Secondly, we have learned that the TVRA funding plays a significant role in torture prevention. The centers we work with overseas are usually prominent in the human rights movement in their respective countries. Often the services they provide extend well beyond torture rehabilitation to include forensic documentation, written and verbal testimony to courts and legislatures, advocacy for the rights of brutalized ethnic, religious, and minority groups, and organizing the public, such as events to commemorate June 26th, the UN International Day in Support of Victims of Torture.

CVT's partner center in Kenya, for example, the Independent Medico Legal Unit, known as IMLU, provides information to the parliament about the incidence of torture in that country's police stations and prisons and forensic evidence to its courts. In turn, the opposition uses the information to challenge the Government to improve its human rights record. This example illuminates the quality of the services IMLU

is providing, and also the fact that torture treatment centers can become allies of democratic governments, not just adversaries of dictatorships.

Let me also point out that we always believed that additional U.S. support for the UN Voluntary Fund for Victims of Torture would leverage new funding from other nations. And we have begun to see that happen. This year, as the U.S. increased its support from \$5.4 million to \$6.9 million, other nations stepped forward with larger gifts as well—among them the Netherlands, Norway, Spain and Italy. We hope Congress will continue its strong support for the Fund by authorizing and appropriating an \$8 million contribution to the Fund in 2006.

Torture treatment centers that have been supported long enough to build expertise and capacity are developing innovative approaches to provide care under difficult circumstances.

For example, the Treatment and Rehabilitation Center for Victims of Torture (TRC) in Palestine developed a highly creative way to use mobile phones to monitor the safety of their field workers and provide care to clients. Due to the volatile situation, curfews and closures and TRC's own intensive fieldwork, therapists often find it impossible to physically visit their clients and vice versa. Using mobile phone networking has proven to be a very successful tactic in ensuring both staff safety and TRC's ability to reach clients to provide essential and cost-effective services.

Other treatment centers are leveraging a relatively small amount of money and preventing torture.

The Centre for Victims of Torture (CVICT) in Nepal, a former recipient of USAID funding, created community mediation as an alternative and adjunct to the criminal justice system. This keeps many people from being needlessly arrested and brought to police stations, where 60 percent of prisoners are tortured into giving confessions. The mediation process enables further investigation or legal action as necessary, including the ability to file a case on behalf of one of the parties. This mediation system is improving community access to justice in the three districts where it has been carried out, and CVICT has been asked to expand the project to twelve districts. That means one-third of the country's population will have access to it—and countless incidents of torture will be prevented.

IMLU, CVICT, and TRC all provided training in the development and use of their tactical innovations at the New Tactics in Human Rights International Symposium CVT sponsored in Ankara, Turkey, in September 2004.

CVT is dedicated to documenting its lessons learned, and sharing that knowledge with other organizations in the US, with our overseas partners, and with our donors. With TVRA support, CVT has initiated a long-term research study to explore the effectiveness of various types of torture treatment strategies across populations, cultures and contexts. This ambitious study is one that has been long advocated for by both CVT's partner centers abroad and donor agencies and should, in time, result in improved interventions that maximize U.S. taxpayer dollars.

#### CHALLENGES

While much good has been done overseas with TVRA support, several challenges remain. There are many areas of the world where torture survivors have little or no access to treatment services, including several countries of the former Soviet Union, such as Uzbekistan; most countries in the Middle East, including Afghanistan and Iraq; and many countries in Africa. I would add that of the top 10 countries of origin of CVT's clients in Minnesota, eight of those countries are in Africa. Through work with the State Department's Bureau of Population, Refugees and Migration, CVT has developed new methods to create targeted resources for torture victims in West Africa, but no viable strategy has yet emerged from TVRA funding to apply the most knowledgeable resources in the field to create new centers in targeted countries.

And there are other barriers to TVRA's effectiveness. The primary barrier is the tendency among large institutional donors such as the U.S. government, European governments and the UN to assume that it is better to spend \$10,000 to treat 1,000 people broadly defined as war traumatized, rather than spending that same \$10,000 to treat 100 people who have been tortured because it somehow represents "more bang for the buck." But there are problems with this reasoning.

First, this approach to development assistance encourages NGOs to do only the minimum necessary to get State Department or USAID funding. Rather, there should be an emphasis on developing an in-house wealth of knowledge that can be shared with the donor, contributing to the worldwide torture treatment and prevention movement, and leaving behind well-established indigenous capability in the country of program implementation. Many of the more broad scale psychosocial programs have little support in the research literature for effectiveness.



And as a donor nation, the U.S. government deprives itself of the opportunity to do serious, clinically-based good and the chance to learn what really works in the field.

By my calculation, less than 40 percent of earmarked TVRA funds channeled through USAID since 2001 have been spent on programming that is, to use the legislation's own language, "in the form of grants to treatment centers and programs in foreign countries that are carrying out projects or activities specifically designed to treat victims of torture for the physical and psychological effects of the torture." That intent was further clarified, for example, by the House Committee on Appropriations in 2003, which stated "Supporting treatment centers as permanent national institutions is the best way of providing treatment services to victims of torture and advocating for the elimination of torture globally." Congress has continued to affirm that, as with any disease, providing the cure as well as the prevention is essential. We at CVT think indigenous treatment centers for victims of torture are the most effective way to accomplish both objectives. While I believe this percentage is increasing, we do have some way to go before we can legitimately say that all money is being used in accordance with the intent of the Congress.

Finally, USAID's requirement that agencies implementing programming overseas with their funds obtain a 25 percent non-US government match is a significant barrier to entry for organizations with expertise in the field of torture treatment and prevention, the vast majority of which are small. CVT, with an annual budget of roughly \$7 million, is one of the largest, yet we are dwarfed by other International NGOs that provide more general emergency response, refugee and development services. We believe there are more than enough of these generalist agencies, and strongly believe it important we focus on torture treatment and prevention. If this barrier was reduced, eliminated, or at least temporarily waived for a certain period of time for organizations below a certain size, that would help all of us to focus on the work of expanding services and knowledge about torture.

#### DOMESTIC CHALLENGES

This problem of trying to distribute a small amount of money as widely as possible also beleaguers the use of TVRA funding domestically. With TVRA, Congress intended to strengthen key regional treatment centers—where knowledge could be created and leveraged into projects that would influence health care, human service and political systems within their spheres of influence and operation. The bill does not fund, for example, torture victims but rather specialized torture treatment programs.

Although the Office of Refugee Resettlement understood many of these concepts, there was a decision early on to encourage programs in many Congressional districts rather than to concentrate funding into those centers most likely to create knowledge and expertise in the field. Groups completely new to the field with no previous experience received grants similar to those who had been laboring in the field as their primary mission of many years. Thus those most likely to have become the training and research institutions needed to build expertise in the field were under-resourced, and had to spend part of those resources training and supporting new organizations. Nonetheless in those first four years of funding, substantial capacity was built at the funded programs. Clinical expertise was developed, treatment capacity was created, and organizational infrastructures were built.

Last year, however, ORR moved significantly away from the priorities it had established in 2000. Twenty-six projects were funded, including 8 new projects. Six projects that had received previous support were not renewed. Of those 6 unfunded programs, 2 closed their operations immediately; the remainder scaled back their operations substantially. (I note that the two that closed their programs had no previous experience in the field, whereas those that scaled back but continued were organizations or providers with a prior commitment to the care of torture survivors.) And we witnessed a new phenomenon in ORR's funding program: support for governmental entities, which was never contemplated by authors of the TVRA.

Of course ORR must operate a competitive grant-making program, and grant-seekers have an obligation to prepare competitive proposals. But it is also important to understand the consequences of not renewing a grant to an established organization. Clinical and organizational capacity that had been established were lost. Torture victims who had been receiving care have nowhere else to turn. And the notion of investing millions of dollars into programs or organizations over three to four years, only to eliminate that funding and cause the program to shut down or dramatically scale back their operations by laying off trained staff, seems like an unwise use of federal resources.

We hope that in the future, ORR will give greater weight to experience in caring for torture survivors when developing review criteria for grants made possible with TVRA funding. We also hope that ORR will resist the urge to reach as many Congressional districts as possible with its limited funds, and return to the original intent of investing in a more limited number of centers and programs. And at least until significant new funding is appropriated, we hope ORR will not give additional weight to proposals that come from regions of the country that are without existing treatment centers.

## CLOSING

I would like to leave you with two final examples to illustrate how TVRA financial support can be leveraged to do much more to treat and prevent torture when it is invested strategically and funded over the long term.

Recently, CVT was awarded a grant from a Minnesota-based foundation to train mainstream providers in one Minnesota community with a significant number of torture victims, including children who were soldiers in their home countries. Currently, the schools, social service agencies and health care providers are overwhelmed with the needs of a highly traumatized population. CVT will provide specialized training and help those providers build a self-sustaining network to give the care and services needed. We are able to do this because of the base of knowledge gained through our direct care to torture survivors, supported by TVRA.

In Bulgaria, the Assistance Centre for Torture Survivors is using its expertise to build and leverage collaborative partnerships for torture prevention training for police officers. The program creates a pool of trained officers who are in turn able to train their colleagues when they return to their own regional police directorates. The training is pragmatic, fostering changes in attitudes and behavior, while giving police organizations and management the knowledge to successfully train their colleagues.

Our understanding of torture treatment and prevention is still new and there is much to learn. Our international work, primarily supported with TVRA funding, is teaching us a great deal about torture, its effects on individuals and societies, creative ways to expose and prevent its occurrence, and how, in the absence of a controlled clinical environment and stable society, one might best help torture survivors in their own countries. And what we learn overseas also enhances our effectiveness in healing the wounds of torture survivors we treat in Minneapolis and St. Paul.

As you consider reauthorization of TVRA, I hope you will keep in mind that torture treatment centers like CVICT in Nepal, IMLU in Kenya, and the Assistance Centre for Torture Survivors in Bulgaria are leveraging a relatively small amount of financial support in creative and effective ways to heal the wounds of torture and prevent torture. I believe this is the intent, and I hope it will be the legacy, of the Torture Victims Relief Act.

Thank you for your attention and your support.

Mr. SMITH. Let me begin the questioning, if I could, with Mr. Sackor. How did you find out about the Bellevue Center? Was it a referral from an immigration or asylum officer?

Mr. SACKOR. From a friend of mine.

Mr. SMITH. Do any of you at the witness table have any suggestions about how we could expand the center-referral process? Dr. Keller, you mentioned that one judge referred the woman from Sierra Leone, and I think there is a spotty record of some judges being very good at referrals and some not. Is there a well-honed referral process, or is it pretty much hit or miss?

Dr. KELLER. We get our referrals, and I think many of the centers do, from a variety of sources. We get a lot of referrals from different human rights organizations, from local immigrant and refugee communities, from local health care providers, and from word of mouth and a lot from training. We do training with the asylum officers in effective interviewing skills, as does CVT and other organizations, and training with immigration objectives.

So it is a lot of things and a lot more outreach we can do, but we are doing limited outreach. We can't meet the capacity. As you

say, you have to be careful what you ask for; you might get it. At this point, we actually haven't done as much outreach.

For example, one of the fatalities in the cuts, it is like a domino effect. You know, you save some things at the expense of others. We had to trim back our educational outreach. We maintained our commitment to training health providers at NYU/Bellevue, but did a lot less training in the field. That was a key area where we were getting—in addition to increasing capacity for individuals to provide care in the community, that is where we were getting a lot of referrals.

There is a lot more we can do for outreach. Whenever there is a story about our program, we get a lot of referrals. We need to know we have the capacity to meet that demand.

Mr. JOHNSON. We have always had excess client demand for our capacity, so at one level, outreach hasn't been necessary. What has been particularly important to us is when there is a new group of refugees coming into our area that we want to take a look at quickly and their experience there so we learn as much as quickly as possible, and then are available to help the broader health care system understand the needs of that community.

CVT abolished its waiting list long ago. We no longer have a waiting list. We don't think it is helpful for the client to be on it. We could do that because we were challenged by Minnesota's Legislature to train the health care systems of Minnesota. We went through a period of about 5 or 6 years where we were training 3,000 or 4,000 health care people a year and establishing partnerships with other clinics where we could train people who could relieve us of our waiting list. And so when we do outreach at this point, we are feeding people into this broader network of services.

CVT concentrates on the most difficult cases, to keep pushing the envelope on what we know. We have just opened up a new program trying to look at new ways of serving our clients, but in particular the Liberian community. We have the second highest Liberian community in the country. We have one second-ring suburb, Brooklyn Park, that is now 20 percent African; not African American, but African, with many Liberians and Somalis highly affected by war traumas and human rights atrocities. So in that situation we have developed a program to train all of the clinics in the suburb to work with this population. We have a project working with all of the school systems in that suburb so that they understand what goes on in the lives of the children who have gone through these traumatic events and how the schools and other social service agencies can participate. And we work with the mutual assistance organizations of the Liberian communities so the leadership is also trained to understand what goes on, what is normal, and what they should be demanding from the health care system for proper care. We can both improve the health care system and create better consumers of health care at the same time.

Under those conditions, we do have a recruitment program, but it is not aimed at getting people fed into our clinic, but rather trying to create a new resource in the community on a different level. And I point out that the only reason we can do it is because we are a mature center that has one of the largest numbers of trained health care people in the area. What limits our ability to do that

and other projects is simply that we are using all of them, and we can only expand so far because we don't have more trained people. What we use to train new people is our client care program. And our desire to expand our own clinical program is to produce more expertise in the field.

Dr. KELLER. If I could add one thing to the outreach. If you need to know where to look, look at the papers. During the Kosovo crisis, for example, we were aware that a lot of families resettled in the New York City area. So we did outreach in the schools. We found that there was a problem that a lot of children were not going to school because in that country when they went to school and came home, their house was in flames. So we did a lot of outreach there in the schools.

Recently we have been getting a lot of referrals from the African community and the Sierra Leone community. We are fortunate to have a psychologist on our staff who is originally from there. So following where the horror spots in the world are and the populations of new arrivals are coming from.

Mr. SMITH. I have a question regarding faith-based organizations—and I have been in many refugee camps around the world. Catholic Relief Services and so many of our NGOs do tremendous work in partnership with Federal dollars. Do you also do the same domestically? You mentioned to me the importance of having a community of people with kindred spirits and like-minded interests, because that isolation obviously works to their detriment. Do faith-based Catholic charities have a domestic component?

Dr. KELLER. We work with a variety of organizations, including a number of faith-based groups. Catholic charities has a robust program for providing legal services. A lot of our clients, one of the crucial interventions is assisting in asylum applications, and they are represented by pro bono attorneys including from Catholic charities. There is a wonderful organization, Christ House, in the Bronx, which is a shelter for asylum seekers. Housing in New York is somewhere between difficult and impossible, as I am sure Sheikh can attest to, and that program has been remarkable. The Lutheran Immigrant Refugee Services has been extraordinary.

We have had some wonderful partnerships with a variety of NGOs and faith-based organizations, and you are right, it is all about partnerships and common ground.

Mr. SMITH. I have two final questions—and we would have liked to have Dr. Wade Horn here to ask him some specific questions, and we will later—on the rationale. Why is the Office of Refugee Resettlement denying funding to organizations that have a proven track record, and have the capacity, and, as you pointed out, are on the verge of breakthroughs only to divert those resources, which we need? The Administration needs to ask for them, and if they are provided at least in an authorized way, they need to work with us to make sure the case is made. You might want to speculate on the rationale behind the diversion of funds away from the experienced providers of these services.

Another question we have, and we saw this with homeless veterans and other people who don't get the services they need, is what happens when the benefits that you provide don't reach those people? Do they commit suicide? Do they end up committing street

crime? Do they batter their spouses? There is a terrible price to be paid for our neglect, and there is even a cost/benefit analysis that could probably be done to show that it is very foolish not to provide these resources. Some of these people have to be ticking time bombs carrying these problems around with them.

Mr. JOHNSON. I would like take the first one, and second one, too. In the presence of a doctor, I would never presume to make an answer. We have a great deal of faith in Dr. Wade Horn's leadership. He is a clinical psychologist, and I think he understands the need for developing effective clinical programs and is concerned as well about the decisions. But I think this is something that needs to be said clearly from you and from Congress, because any agency lacking perhaps other expertise on defining what is effective and what is not has a tendency to look at numbers and to say at least we are seeing more numbers than a few. It is important for you to clarify what you want as outcomes at this point.

I will give you the horror story for me which has kind of defined a lot of my work over the last decade, but in dealing with that kind of mentality. Warren Christopher indicated that he wanted us to be involved on the Bosnian program, and they sent a number of people for us to be trained. And so we had groups of 30 Bosnians for a fairly extensive period of time. We went back and forth and did programs, and out of that we concluded what was needed was to establish a treatment center in Sarajevo, recognizing that we would see a very limited number of people; that we thought that what was needed was to establish a learning center in this field.

We discovered that there were a lot of psychologists in former Yugoslavia, but they were all trained as personnel officers and had no clinical experience. Where would you create a capacity? We proposed doing that with a treatment center together with the American Refugee Committee. We did not get that grant. Instead it went to a program for—I think it was women's sewing circles, and in the promise that thousands of women would benefit from the symptoms of war trauma if they gathered together in sewing circles; no data or research that indicated that was successful, but the promise that many more people somehow—that thousands rather than hundreds would be aided directly.

About a week after that grant was given, the agency that received it called me up and said with great excitement they had received this grant to work in Bosnia and didn't know how to do it, and would I supply the staff from the center to do this. Well, we presented a proposal to create capacity. They presented a proposal to use capacity.

My contention is at this time in the history of this movement is the time to create capacity and to bend everything we can into that creation, and not to dissipate it, especially in unproven programs.

Dr. KELLER. First to your question in terms of why the diversion of funds, clearly that is a question for ORR to answer, and I can answer on a few things. As Doug alluded to, perhaps the numbers issue is driving it, perhaps the geographic diversity. When we advocated for more funds, we had two messages. It was, one, we need more support ourselves, the existing center, to meet the demands, and there were unmet needs around the country. Unfortunately, we

got in a sense half of what we asked for. Some new centers were created, but it came down to robbing Peter to pay Paul.

I, in the process of deciding the grants—and I understand there was a request for proposals, and they were evaluated, but I was dumbfounded when I learned—and I invite Members of the Committee or anyone interested to come and visit our center. Modesty aside, I never had a visitor come who wasn't just extraordinarily impressed, surprised, inspired by what they saw. So we had site visits from folks from ORR, and those evaluations were never considered into the considerations for refunding. In fact, I know they weren't. And those individuals who did the site visits, I know a lot of them were not on the panel or whatever that decided the grants.

Also based in the RFP was a call that, okay, there was additional funds, you got additional points for being a new center. And I do share some of the concern that Doug alluded. I am an internist and not a psychologist or psychiatrist. I get concerned about a bias, a stigma against mental health and refugee mental health. It is absolutely true that it is wrong to overpathologize refugees as it is anyone else, and it is wrong to stick your head in the sand and to not acknowledge that there are treatable problems, pain and suffering. And so there are balances. Sewing circles are good and can be important, but not at the expense of real core services.

So to answer your question of what happens to those who don't get services, that study really hasn't been done. In fact, it would be a challenge to do a controlled study of people who get services and those who don't, although I think at least scientifically we could learn a lot. I can tell you from those we care for that in the data that we have been able to collect, and as Mr. Tancredo did allude to, I think the outcomes issue is crucial to follow. But when we run into survival mode, collecting the outcomes data became a lot more difficult. We were trying to help those who were already at our doorstep.

Among the clients we care for, we see a marked improvement in symptoms; if you measure certain things, sleep, that individuals come to our program and haven't slept more than 2, 3 hours in months, I can't imagine what that would do. So I am if—we did a study in the community of untreated torture survivors, the lack of sleep is horrific. Marked improvements in symptoms of individuals who come through our program. Marked improvement in the sense of well-being and quality of life.

We follow outcomes in terms of employment, individuals who are working and who aren't. If you look in the community, employment levels are higher. So I think the burden of pain and suffering among those not treated is immeasurable.

I must say among the tortured survivors I have cared for, I am inspired at the lack of violence. I don't know that these are necessarily ticking time bombs, but many individuals, I would say, there is profound pain and suffering that is going unaddressed.

Mr. SMITH. Ms. McCollum.

Ms. MCCOLLUM. I thank the Chairman.

Thank you for the testimony, and thank you so much for sharing your journey with us, and I wish you many happy days and years ahead as you continue to work on your recovery.

What I am hearing is that we need to come back after talking to ORR, and if we want to continue fulfilling our mission of building capacity, because that is the only way that we are going to be able to reach out to all the people who are coming forward and all the people that we heard in Full Committee yesterday in the Sudan, that we need to really address this with reauthorizing language. And I think Mr. Johnson came out and said that, but you feel that is the only way, that—your focus on building capacity so we can eventually staff fully new centers which can be effective both nationally and internationally?

Mr. JOHNSON. To give you another example of capacity, if I could, we were asked by the Bureau of Population Refugee and Migration from the State Department to go to Guinea and into Sierra Leone to work with survivors of torture from Sierra Leone. This is a country devastated by human rights atrocities, tens of thousands of people affected directly and indirectly. In the country there was only one psychiatrist. He runs the mental health wing in the hospital and runs the mental health department of the Health Ministry, and he tried to start a treatment center for torture victims. He was it, the only game in town. In a time and place like that, what do you do?

We were moving into the refugee camps. What we decided to do was train refugees to become psychotherapists. We call them psychosocial agents. We focused on creating capacity, but how could we do it? The way we thought to do it was, first in Guinea and then in Sierra Leone, we brought in five, well-trained psychologists with experience in trauma and torture. And where did we get them from? Most of them we got from the other treatment centers, from our colleague organizations; a number of them came from programs that we work with under a USAID contract, and our international capacity-building project from South Africa, from Kenya, from Nepal. If those centers had not existed, we could not have done what we did in Sierra Leone. But what we did do with daily supervision was to train 125 Sierra Leone refugees to become psychotherapists. Eighty-seven of them received university degrees based on the extensiveness of the clinical training we provided for them.

So here is a situation where capacities did not exist, and we created it. But the only way we could create it was to draw on the capacity of ourselves and our colleagues, where we could, with a little bit of surplus, pull it together and put it to work in a new way. Unfortunately, because PRM is focused on the emergency crises and the refugee program, once people started moving back in their communities and we moved with them, the funding ended. So it has been a struggle to find how we keep that capacity at work in a community that is very deeply divided; we hope for USAID, but other forms of support for the long-term capacity. We have now done the same thing in Liberia. We have now moved into Liberia, having first worked in the refugee camps.

But that is an example of how capacity could be built when we relied on capacity that others had built to help us out. People in State liked that program, and they at one point gave us a list of places they would like us to work. And we had to say, hold on,

there aren't enough trained people in the world to go do this and create the level of services and the quality that we think is needed.

And secondly, we don't know yet how to raise the 20 percent that we have to do for each of these projects. So we have to go slowly. The capacity on several levels is simply not there. And as we add that capacity, we are willing to be of more service to other places, but in particular we know to do that, we will have to draw on our colleagues' capacity.

Ms. MCCOLLUM. Thank you.

Thank you, Mr. Chair.

Mr. SMITH. The Chair recognizes Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chair. I would just like to—we have had 2 good hours of discussion, I think, very thorough.

Mr. Chairman, if you don't mind, we have the markups we would like to do. I will yield my time, but I would just urge the persons, you know, the other Members that might have just gotten here, if we could—I will yield my time to them if they have a question, but I need to be out of here at 4:30, and I would like to participate in the markup, so I won't ask questions.

You do great work. Appreciate it. I was just going to ask about the immigration, some of the asylum hearings where I really think that those judges are totally partial; partial that every single immigrant or refugee that comes seems that they don't have what they are supposed to have in order to be given asylum. Very rarely is asylum given. I think that it is done improperly and wrong. But I won't get into that because I do want to let the Chairman finish with the work of today. And like I said, 2 hours have been excellent. I appreciate it.

Mr. Sackor, I commend you for your courage and just hope you can go back to your country when the elections happen and be a leader in Liberia. Thank you very much.

Mr. SACKOR. Thank you.

Mr. SMITH. Would any other Member like to be heard?

Mr. SHERMAN. I would just like to thank the Chairman and Ranking Member for holding these hearings and second the views of the gentleman from New Jersey.

Mr. SMITH. Thank you.

I would like to truly thank our distinguished panel. You did a tremendous job, but, more importantly, you are providing real help and assistance to so many people who otherwise would carry the pain and the scars of torture. You are mitigating some of that pain and helping to cure those people. Obviously, the cure is lifelong.

And to Mr. Sackor, I just want to thank you so much for your testimony because this helps us to know what this is all about.

I remember we had a victims panel when we did the first bill in the 1990s, and I was just devastated after hearing about the pain, suffering, and sleepless nights. This helps us to know and be motivated to act on this important issue. It gets no coverage, and is hurt by that obscurity. You have helped to bring it to light for us, so thank you to all three of you.

The hearing is adjourned.

[Whereupon, at 4:03 p.m., the Subcommittee was adjourned.]